

OLDER AMERICANS ACT REAUTHORIZATION AMENDMENTS OF 1991

HEARING
BEFORE THE
SUBCOMMITTEE ON AGING
OF THE
COMMITTEE ON
LABOR AND HUMAN RESOURCES
UNITED STATES SENATE
ONE HUNDRED SECOND CONGRESS
FIRST SESSION
ON
S. 243
TO REVISE AND EXTEND THE OLDER AMERICANS ACT OF 1965, AND
FOR OTHER PURPOSES

JANUARY 31, 1991

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OLDER AMERICANS ACT REAUTHORIZATION AMENDMENTS OF 1991

THURSDAY, JANUARY 31, 1991

U.S. SENATE,
SUBCOMMITTEE ON AGING, OF THE COMMITTEE ON LABOR AND
HUMAN RESOURCES,
Washington, DC.

The subcommittee met, pursuant to notice, at 9:40 a.m., in room SD-430, Dirksen Senate Office Building, Senator Brock Adams (chairman of the subcommittee) presiding.

Present: Senators Adams, Pell, Metzenbaum, and Cochran.

OPENING STATEMENT OF SENATOR ADAMS

Senator ADAMS. Good morning.

I am pleased to convene today's hearing of the Subcommittee on Aging, which will be in this case the first hearing since I have become chairman of this subcommittee and we have reconstituted the committee for this year.

This is both my first hearing as chairman of the committee and our first hearing concerning the reauthorization of the Older Americans Act. By September of this year, we must complete the reauthorization, and to help accomplish that I will hold a series of hearings. We will try to cover all of the key issues concerning the Older Americans Act over the next several months.

Just last week, I introduced S. 243, "The Older Americans Act Reauthorization Amendments of 1991", to serve as the Senate's vehicle for reauthorization. S. 243 is a straight reauthorization of the current Act; it does not include substantive amendments at this time. That is because it is important that we take time to listen carefully to the witnesses and to those who have had a long understanding of the OAA and the needs of the elderly.

After doing that, and particularly through the hearing process which we start this morning, we will work to craft a thoughtful and hopefully realistic set of amendments to this important legislation. I mention that so that you understand that the bill that has been introduced is a vehicle and is not intended to be the final work on this particular project.

These amendments which we hope will be offered will reflect the testimony that is presented at our hearings as well as information from other sources and related hearings and the ideas offered by our colleagues in Congress.

As all of you who have dealt for many years with the subject of our senior citizens as I have—and I have been in the Congress off

and on since 1964, there are many committees, select and otherwise, that deal with the problems of our senior citizens. It just so happens that this is the committee that has jurisdiction to pass the necessary legislation. That is why it is so very important that we not only hold hearings but that we receive information from all of the various groups, committees and otherwise that are working with this problem so that we craft the best possible piece of legislation.

There are a number of important issues to be addressed during this reauthorization. In 1987, when he introduced his Older Americans Act reauthorization bill, my predecessor and very dear friend, Senator Spark Matsunaga, who we miss very much, expressed his concern over the "apparent decreases in service to minority elderly individuals" and "the problems of racial and ethnic minority access". In 1991, these concerns continue to be even more pressing.

Then there are many other issues, small and large, to take up this year. I have made available this morning my statement accompanying the introduction of S. 243. Rather than taking the time here to outline it, I would refer you to that statement since it outlines other areas of concern, including some of my particular interests that I hope we can address in 1991.

We are at war—on several key fronts—in addition to the dramatic and obvious of the Persian Gulf. But we have an economic war fully underway, one that deeply compounds the raging warfare in the Persian Gulf. Many of America's older citizens, like so many others, especially our children, have great needs that are larger than the resources we are providing. That will not change, at least in the immediate future. We know that 1991 is not a friendly year for major new expansions in domestic programs, including the Older Americans Act. That saddens me, but that is a fact, and therefore we must face it and deal with it. And I appreciate the witnesses who will be here today to help us do that.

Nevertheless we have the opportunity to significantly improve the Act. We will build on the successful and remarkable foundation established by the Older Americans Act in 1965 and strengthened through various amendments over the past 25 years.

One of the things we can do is to ensure that needy and vulnerable older persons receive that which they are entitled to and need. We can ensure that their rights, established over the years and often after much hardship, are protected.

Who are we talking about here? We are talking about those who live in institutions and other settings where they are dependent upon others. They are those who are abused, neglected or exploited due to their circumstances, including poverty, physical and mental incapacities, and yes, isolation.

Much too often these are low-income women and minorities. They are also those who simply do not have the wherewithal or the knowledge to access our systems, which are intended to help them, or to obtain the assistance or simple justice they need and deserve and simply do not know is available.

By that, I mean the right to be free from abuse and exploitation and the right to be free from discrimination in the workplace and elsewhere; the right to obtain crucial benefits such as Medicaid and SSI; the right to a safe and quality environment in nursing homes

and other settings where they may be existing—and I use the word “existing”—we would rather have them “living” than “existing”—and most importantly, as spelled out in the Declaration of Objectives, “Freedom, independence and the free exercise of individual initiative in planning and managing their own lives.”

That's what today's hearing is about. We will discuss those aspects of the Older Americans Act that are devoted specifically to the rights of the elderly. These include the long-term care ombudsman programs, legal assistance services, and new efforts to prevent elder abuse. This should provide us insight into their value and impact, as well as how we can improve those efforts.

I also hope that today's testimony will address the potential of the OAA and the “aging network”—the Federal Administration on Aging, our State and area agencies on aging, and the many local service providers—so that they will be more responsive to protecting rights and preserving autonomy for our vulnerable older citizens.

We have a distinguished group of witnesses today. They come from all over the country and have extensive experience with the Older Americans Act and the rights of older persons. They include people who have served at all levels in the aging network, from the Federal level to the local community level. We also have a very special person, someone who is deeply committed and who had to call upon the services of the Act to deal with difficult problems affecting a loved one.

Our witnesses will provide us with the benefit of their wisdom and insights from both retrospective and current perspectives.

I am, of course, especially pleased that two of the witnesses have come from my home State of Washington. Ty Duhamel represents Evergreen Legal Services, which runs one of the Nation's finest senior law programs. Pat Lashway, from the Washington division on aging and adult services, played a key role in establishing Washington State as one of the strongest supporters of legal assistance through the OAA.

And as we will hear from Maryland's health insurance counseling and advocacy program, I'd like to mention that Washington has the country's oldest senior citizens health insurance counseling program, known as SHIBA.

Because of the many cases of abusive sales and marketing practices by insurance agents and companies that SHIBA has uncovered and taken to our insurance commission, our State has established itself as effective in combating such practices, and I recommend it to other States to examine the practice.

Before turning to my colleague and very good friend, who I am so pleased is serving as the ranking member on this committee, and to our dedicated and knowledgeable witnesses, who represent the real strength of the OAA, I'll take the liberty of quoting Dr. Arthur Flemming, who is going to be our lead witness today. In commenting on the demonstration project that became the basis for long-term care ombudsman in the Older Americans Act, which he initiated as U.S. Commissioner on Aging, Dr. Flemming said: “Our Nation has been conducting investigations, passing new laws and issuing new regulations relative to nursing homes at a rapid rate during the past few years. The individual in the nursing home is

powerless. If the laws and regulations are not being applied to her or to him, they might just as well not have been passed or issued."

Well, that final point is true for all citizens who may be truly vulnerable. The Older Americans Act, due to the leadership of those we shall hear from this morning, and many others, has done a great deal already. I hope this hearing and the reauthorization of the Act will enable us to do even more, even better.

Now, it gives me a great deal of pleasure to introduce to those who don't know him—and I think most of you do—the ranking member of the committee and an old friend, Senator Thad Cochran of Mississippi.

OPENING STATEMENT OF SENATOR COCHRAN

Senator COCHRAN. Thank you, Mr. Chairman.

Let me join you in welcoming our witnesses to this first hearing on the reauthorization of the Older Americans Act. I want to congratulate you on your decision to accept the chairmanship of this important subcommittee. It is, I think, a wonderful opportunity for us to begin our hearings talking about the needs of the vulnerable elderly and how the Older Americans Act can help address those needs in a sensitive and caring way. We are confronted with budget constraints, which everybody understands, but that doesn't constrain our interest or our desire to try to help do the best we can for the older members of our society.

During the past 25 years, the Older Americans Act has become a vehicle for the delivery of important supportive, nutrition and other social services to our older citizens. The rapid increase in the population, proportionately, of this group in our society is going to test our ingenuity in the days and years ahead as we try to make sure that we continue to meet the ever-increasing need for services under this Act.

Today's hearing is a good place to begin, and I look forward to hearing the testimony of all of the witnesses.

Thank you, Mr. Chairman.

Senator ADAMS. Our first witness this morning is Dr. Arthur Flemming. He really doesn't need any introduction because it is hard to imagine anyone who has worked at all in this field who does not know Dr. Flemming. He is one of the Nation's most articulate, effective and knowledgeable advocates.

But not as an introduction, but really as sort of eulogy to you, Dr. Flemming, you have entered your eighth decade of a remarkable career that represents just about all that is right in public service, and I can't possibly do justice to you in trying to read all of those, but I just want to say that in particular your views as U.S. Commissioner on Aging from 1973 to 1978, and the things that you did with this Act, and the things that you did as Secretary of HEW from 1958 to 1961, and then your tenure as chairman of the U.S. Commission on Civil Rights from 1974 to 1982, mean that you have dealt with all of the people problems of this Nation, and your Nation is grateful to you, and we are very pleased to welcome you as our first witness today.

The rule that the chairman will use this morning on witnesses is that we will ask all except Dr. Flemming to limit their statements to five minutes, but we'll place all statements in the record.

I do that only so that we can hear everyone, so please don't feel we're trying to cut anyone off.

Dr. Flemming, welcome to the committee. It is a great pleasure to have you here this morning.

STATEMENT OF ARTHUR FLEMMING, CHAIRMAN, SAVE OUR SECURITY, AND FORMER U.S. COMMISSIONER ON AGING, WASHINGTON, DC

Dr. FLEMMING. Senator Adams, I appreciate very, very much the opportunity of being here, and I appreciate very much your very generous comments.

I am delighted that you and your colleagues on the subcommittee are beginning your hearings on the reauthorization of the Older Americans Act by focusing on the role and effectiveness of the Act in protecting the rights of the vulnerable elderly.

Naturally, as I think in terms of the Older Americans Act and what has happened since its passage in 1965, there are many issues that come to my mind; many issues that I am always happy to discuss with interested persons. But I am particularly happy to be invited to discuss this specific issue with the committee as you begin your hearings on reauthorization.

As you indicated, I was appointed US Commissioner on Aging in 1973. The 1973 amendments to the Older Americans Act provided the foundation for the development of a network of State and area agencies on aging.

We assumed—those of us who were associated with the administration in 1973—that advocacy in behalf of older persons, with emphasis on vulnerable older persons, was one of our major responsibilities. Personally, I am delighted that the Act now includes specific responsibilities for advocacy for the US Commissioner on Aging as the head of the Administration on Aging, the administrators of State agencies on aging and the administrators of area agencies on aging.

I have included in the outline of my testimony quotes from the law, laying out these advocacy responsibilities. In the interest of time, I will not include all of those quotations in my oral testimony this morning, but I would like to say this. The wording in the charge to the Administration on Aging and therefore to the Commissioner on Aging appeals to me, and always has appealed to me particularly, namely that “it shall be the duty and function of the Administration on Aging to serve as the effective and visible advocate for the elderly.” I like that language. I like that way of stating the charge.

The State agencies, of course, are charged also to “serve as an effective and visible advocate for the elderly”—virtually the same language.

There is a little change when it comes to the area agencies. They are charged or told to “serve as the advocate and focal point for the elderly”.

But the message is the same as addressed to the US Commissioner on Aging, to the heads of the State agencies on aging, and to the heads of the area agencies on aging. The Congress expects them to be vigorous and effective advocates in behalf of older persons and especially the vulnerable.

The Act makes it clear, in fact, that in discharging all responsibilities under the Act, including the responsibility of advocacy, preferential consideration shall be given to those "with the greatest economic and social needs and to all vulnerable elderly".

The Act says that "the term 'greatest economic need' means the need resulting from an income level at or below the poverty levels as established by the Office of Management and Budget."

The Act also says that "the term 'greatest social need' means the need caused by noneconomic factors which include physical and mental disabilities, language barriers, and cultural, social or geographical isolation including that caused by racial or ethnic status which restricts an individual's ability to perform normal daily tasks or which threatens such individual's capacity to live independently."

In brief, the Act says to those involved in its administration, charged with the responsibility of advocacy: Open up the doors of opportunity for the poor, the isolated and the victims of discrimination.

Finally, the Act as it has developed up to this point has provided those charged with the responsibility of advocacy with access to two very important processes—the legal service process and the ombudsman process—these are open to them and available to them—in their efforts to make sure that older persons have access to and receive the quality of services to which they are entitled by law.

It is my belief that an excellent start has been made in building a legal foundation on which an effective advocacy program designed to protect the rights of older persons, especially vulnerable older persons, can be developed.

I am sure that the hearings of this subcommittee will establish the fact that some real progress has been made in establishing such a program. I am likewise sure that the hearings will also identify some missed opportunities.

I note, for example, that in at least two parts of the Act, specific responsibilities are assigned in connection with Title XVI of the Social Security Act, or the Supplemental Security Income Program for the Aged, Blind and Disabled.

Right now, I am chairing a group of persons from outside of government that has been brought together by Social Security Commissioner King to participate in what she has designed as the SSI Modernization Project. As you know, under the law, as far as the social insurance programs are concerned, every 4 years an advisory group is established from outside of government to take a look at the programs and to make recommendations to the President and to the Congress.

This part of the law has not been applied to the SSI program. Up to now, no group from outside of government has ever taken a look at the SSI program since it got started in 1974. Personally, I regard it as a privilege to have the opportunity of participating in this particular project.

As a result of our deliberations to date and of the opportunity that I have had to visit local Social Security offices within the Social Security regions, I have concluded that the Administration on Aging as well as other public and private groups have missed many

opportunities to serve as effective advocates for the poorest of the poor among the elderly, the blind and the disabled.

Since we succeeded in getting this law enacted in 1972, it seems to me that there has been a tendency to kind of turn our backs and forget about it and not follow through in connection with its implementation in an effective and meaningful manner.

Then, to take just one additional example, I also believe that the Administration on Aging as well as other public and private groups have failed as advocates in protecting the rights of older persons under the Age Discrimination Act.

As you know, Congress in passing that Act said that it would be illegal, unlawful, to discriminate in the delivery of services supported in whole or in part by the Federal Government on the basis of age.

While I was serving as chair of the US Commission on Civil Rights, the Congress asked us to conduct field studies, hold public hearings, conduct an investigation to determine to what extent there prevailed in the delivery of services supported in whole or in part by the Federal Government the practice of ageism, discrimination on the basis of age.

As a result of our hearings and as a result of our field investigations, we concluded that discrimination on the basis of age was widespread. For example, we took note of the fact that in connection with the mental health programs, particularly the community mental health programs, the percentage of persons being served by those community mental health programs who were 65 and above was a very low percentage, running for the country as a whole around 3 to 4 percent.

We had as witnesses under oath in our public hearings persons responsible for the administration of those community mental health programs. We asked them why they were not reaching the lives of more older persons. The literature made it very clear that at least 20-25 percent of older persons could benefit from those services.

The initial response was: They don't come to us. We said we can understand that, but what efforts are you making to go to them and to talk with them about the services that you are able to render? Normally, the response was: We are not making any efforts because we do not have the funds to do it.

But then, as we pressed, we at times I felt got the real answer. Some of them said: Look, we have limited resources, and we believe that it constitutes a better use of those resources to focus on children, youth, middle age, than on older persons.

I remember a dialogue with the head of one of the units where I said I think I get your message; you figure we're not going to be around very long, so why worry about our mental health. His response was: I wouldn't put it quite that way. I said, no, maybe you wouldn't put it quite that bluntly, but that is your message.

It is clear that the Age Discrimination Act is not being implemented in an effective manner. It is clear that ageism is widespread in the delivery of services financed in whole or in part by the Federal Government.

I believe that a part of the advocacy responsibilities the US Commissioner on Aging, of the heads of State and area agencies on

aging, is to take note of the fact that that Act is not being administered in an effective way and to serve as advocates designed to bring about a more effective implementation of the Act.

Both of my illustrations relate to laws that are administered by units in the Department of Health and Human Services that are not administered by and where the Administration on Aging does not have direct responsibility for administration.

The Administration on Aging must, of course, recognize its advocacy responsibility in connection with the programs for which it has responsibility—its responsibility, for example, to ensure that preferential consideration in the delivery of services is given to the poor and other victims of discrimination. But from the beginning, the Congress has emphasized the Administration on Aging's responsibilities as a watch dog in connection with many other programs administered by other agencies which play a major role in the lives of older persons.

For example, in spelling out the advocacy responsibilities of the US Commissioner on Aging, the Older Americans Act identifies the following programs related to the purposes of the Act—and I list them in my testimony—the Job Training Partnership Act, Title II of the Domestic Volunteer Service Act, the SSI program to which I have already referred, Medicaid, Medicare and so on, and certain specific sections of the National Housing Act as well as Title I of the Higher Education Act of 1965 and the Adult Education Act.

I believe that advocacy, as conceived of by the Congress in the Older Americans Act, should be at the top or close to the top of the Administration on Aging's action program. I do not believe it is there at this time. I believe that the Congress and the field of aging share responsibility with the Executive Branch for the present situation.

I believe that the Congress could play an important role in elevating advocacy in the Administration on Aging by taking the following steps.

One, bring the advocacy assignments and the processes supporting those assignments—the ombudsman and legal service—that are now in the Act together in a new title, a title that would be dedicated to this whole role of advocacy.

Second, grant the US Commissioner on Aging, as a part of the advocacy functions assigned to the office, the authority to hold hearings and, as a part of the hearings to subpoena witnesses and place them under oath.

In drafting this authorization, I suggest that consideration be given to the manner in which the US Commission on Civil Rights was authorized to proceed by the Congress.

Let me return to the Age Discrimination Act for a moment. The Congress gave the US Commission on Civil Rights a specific mandate to conduct the hearings to which I referred. It seems to me that it would have been more appropriate for the US Commissioner on Aging to be in a position to conduct those field studies and to hold those hearings.

I believe that if the US Commissioner on Aging were given this kind of authority that it would serve to elevate in a very significant way the whole advocacy responsibility.

I also suggest that consideration be given to authorizing the US Commissioner on Aging to delegate authority to hold specific hearings to an official reporting to the Commissioner and to State and area directors of aging.

Third, I would suggest that the Congress consider amending the language in the existing Act relative to the ombudsman process so as to make it possible for this process at the Federal, State and area levels to be of maximum assistance to the US Commissioner on Aging in the discharge of advocacy responsibilities, including the holding of hearings, and also of maximum assistance to State and area agencies on aging in their discharge of advocacy responsibilities.

This would mean broadening the jurisdiction of those who have responsibility for the ombudsman function. Right now, it is confined to the long-term care area, with specific emphasis on long-term care institutions. But I think it would be worthwhile to consider the desirability or possibility of broadening the jurisdiction of the ombudsman, particularly from the standpoint of the ombudsman process being of maximum assistance to the US Commissioner on Aging, to the State directors on aging and the area directors on aging in the carrying forward of the advocacy responsibilities that have been placed upon them by the Congress.

I believe that a strong advocacy program is a "must" if the rhetoric of the "Declaration of Objectives for Older Americans" as set forth in Title I of the Older Americans Act and the rhetoric of the titles designed to carry out the declaration is to be translated into reality for a maximum number of the older persons of our Nation.

I hope that this committee will start us down the road that will bring together the pieces of our present advocacy program into a new section, and then will strengthen the various components of the program.

Above all, I hope that the members of the committee will do everything within their power to see to it that adequate funding is provided.

I am deeply concerned about the attacks that are made on public servants for their failure to discharge adequately responsibilities of this nature when what is missing is not lack of will, but lack of resources.

For example, I notice that the Congress did specifically say to the Administration on Aging, to the Commissioner on Aging: We want you to participate in the carrying forward of outreach programs in behalf of the Supplemental Security Program, in behalf of the Medicaid program. But I also have noted in a report that has been made on that particular matter that no funds have been appropriated to carry out this particular mandate.

I am well aware of the difficulties that are involved in dealing with this issue, but I believe that we must confront them together, those in the government and those outside of the government, and find some way to overcome them.

Mr. Chairman, I note with a great deal of satisfaction the fact that you not only chair this subcommittee but that you are also a member of the Appropriations Committee, and that does provide an opportunity to build a bridge between the actions taken by a legis-

lative committee such as this committee and the Appropriations Committee.

I have become very much impressed with the importance of this issue as I have worked on the Supplemental Security Income assignment to which I have referred. There, we have a seriously understaffed situation, and as a result of it, an inability on the part of dedicated, committed career civil servants to do what they want to do in terms of rendering the kind of service that should be rendered to those who are the beneficiaries of that particular program.

I feel it is a very serious issue involving the credibility of government in the minds of our people.

I do thank you for this opportunity of addressing this particular issue of advocacy and its relationship to the vulnerable elderly. I look forward to talking with you further about this, and with the members of your staff, and I will also be delighted to have the opportunity of talking with you and the members of your staff on other issues involving the Older Americans Act.

Thank you very much.

[The prepared statement of Dr. Flemming appears in the appendix.]

Senator ADAMS. Thank you very much for an excellent statement and particularly for your suggestions. I have some questions. We will limit ourselves to the five-minute rule as we do that, and also the other witnesses.

First, I would note that Senator Pell has joined us. Welcome, Senator Pell. We have made opening statements. We would welcome one from you, if you would like to do so at this time, and then we'll proceed with some questions.

OPENING STATEMENT OF SENATOR PELL

Senator PELL. Thank you very much indeed, and I thank you, Senator Adams, for holding and chairing today's hearing on this topic of such importance to our senior citizens.

The Older Americans Act became law in 1965, and I was proud to join in introducing that legislation at the time, 26 years ago. In the years since, I have been glad to give OAA my strongest support.

I would ask unanimous consent to insert the balance of my statement in the record, Mr. Chairman, and I would just note how fortunate we are to have Dr. Flemming with us. I was particularly struck by his reference to the importance of the Appropriations Committee, which I often refer to as our "politburo". [Laughter.]

Senator ADAMS. Thank you.

[The prepared statement of Senator Pell follows:]

PREPARED STATEMENT OF SENATOR PELL

Mr. Chairman, I thank you for holding today's hearing on this topic of such great importance to our Nation's senior citizens.

As you know, the Older Americans Act (OAA) became law in 1965. I was proud to join in introducing that legislation—some 26 years ago now—and have, in the years since, been glad to give the OAA my strongest support. I am pleased to be here today to show my support for the reauthorization of this important law.

Today's hearing will help us define and respond to a troubling and dramatically increasing problem in our society: abuse of our elderly. That abuse—emotional and physical—must be recognized and stopped. Our seniors deserve no less, and in fact deserve the very best that we can give them.

The reauthorization of the Older Americans Act offers us an excellent opportunity to address this serious problem—and other problems and needs of the elderly—sensibly and soon. I look forward to working with you, Mr. Chairman, and the other members of the Aging Subcommittee, on all aspects of this important legislation.

Thank you.

Senator ADAMS. I have one question to you, Dr. Flemming—I have a number, but there is one that I want to highlight, and then I'm going to turn to my colleagues for their questions.

Really, as father of the long-term care ombudsman, you know how it works in nursing homes. I know everybody in this audience, and certainly I personally have had more experience than I would really like to have in dealing with nursing homes and the necessity for an ombudsman. Do you think this notion is something that we could or should extend to other problems affecting the elderly, for example, board and care areas and others similar to that, because with the nursing homes we have groups of people who are more easily reached, but we have been hearing stories that were not good ones about board and care and other types of institutions.

Dr. FLEMMING. Mr. Chairman, for some of the reasons that I indicated in my opening statement, I believe that consideration should be given to extending the process to other areas.

Senator ADAMS. You suggest that this Title III—and I have a great deal of interest in that, and I will be discussing it with my colleagues—I think that may be a way of approaching a manner of broadening this without our getting into areas where we simply can't afford them. And when I say "can't afford them", what I am most concerned about, and I think it should be stated very publicly—and Senator Cochran is a member of the Appropriations Committee just as I am—is that we do not want the appropriations process this year—and I fear it will be—to be one of taking from one disadvantaged group and giving to another. That is our great fear. Therefore, we want to try to authorize and to direct authorization statutes to get the maximum effect. That is why I asked you that, if we are doing the ombudsman, advocacy and examination effect, we probably should be working on changing the authorization so that existing people can do more, and then we'll try to get them some money.

Dr. FLEMMING. I feel that it would be a good thing to bring together, as I indicated, in one title what the Congress has really already staked out as duties and responsibilities in the advocacy area. As I have re-read the Act, I recognize that the advocacy function is referred to and is included in a great many places in the Act, and I think we would gain by bringing it together under one title.

Now, in doing so, I think that we should then look at a service such as the ombudsman service and see whether or not, as it is now constituted, it is rendering the maximum possible service to

the US Commissioner on Aging, to the State directors on aging and area directors on aging in the carrying out of their advocacy responsibilities.

Of course, I recognize that if we ask those who are now discharging ombudsman responsibilities to add to those responsibilities and move over into other areas, we are adding to the work load, and it will require additional resources. I think that ought to be looked at very frankly. And if those resources are not going to be made available in fiscal 1992, but we still feel that this would be a good thing to do, well, then, I think that certain parts of the advocacy title probably should be identified as parts that become operative in fiscal 1993 or something like that. In other words, phase in to what might be regarded as a good, sound development in the advocacy area.

But I do believe that the process itself is a sound process, and that if it is carried on in other areas, it will add real meaning to this responsibility of advocacy in behalf of the vulnerable elderly.

Senator ADAMS. Thank you, Dr. Flemming.

Senator COCHRAN. Thank you, Mr. Chairman.

Dr. Flemming, thank you for your very thoughtful testimony. It is obvious that you have looked at the Older Americans Act with a view toward making some specific suggestions to the committee today, and I personally appreciate that.

Dr. FLEMMING. Thank you.

Senator COCHRAN. The observations you make as a result of your visits to Social Security offices I also found particularly interesting, and I wonder if you came up with any ideas for improvement or reform in the way the people who deal with those offices could be treated in a more sensitive way. You talked about advocacy, and I think in your testimony you stated that the Administration on Aging and other groups have missed opportunities to serve as effective advocates in connection with the observations you made from your visits to the Social Security offices. I was wondering what specifically you might recommend in the area of advocacy in connection with the Social Security Administration?

Dr. FLEMMING. Senator Cochran, first of all there is no doubt at all but that I think many of us have missed opportunities in terms of outreach as far as the Supplemental Security Income program is concerned. There is no doubt at all but that there are a good many persons in this country who are eligible for the Supplemental Security program, either aged, blind or disabled, who are not on the rolls, and they are not on the rolls in many, many instances because they are unaware of the program or because the program has not been described to them in an adequate manner.

But let me also respond to your question by identifying what I feel is another responsibility in the advocacy area. Included in Title XVI, which is the Supplemental Security Income program, is a provision which says that if a beneficiary moves into a household, that the benefits are to be cut by one-third.

Now, there is language there which makes it possible to waive all or a portion of that one-third cut, also. I have discovered that the administration of that particular title has become so complex that it takes up 100 pages of the manual in connection with the SSI program. I have discovered that it takes one-third to one-half

of the time of all of the persons engaged in the claims process. If people had followed the implementation of that particular title carefully over the years, I'm sure they would not have any trouble in determining that that is an unsound public policy, that provision of law. Here we are—we are dealing with the poorest of the poor, among the aged, the blind and the disabled, whose incomes are below an income floor which in turn is below the poverty line. And if they are fortunate to be able to work out an arrangement to live with a son or a daughter or brother or sister, or a friend, the government comes around and penalizes them for having worked that out; whereas we've got other programs, as you know, where we provide incentives for persons to stay in households, and as we think in terms of health care, we are saying that probably our greatest opportunity in the field of health care is going to be connection with home care.

So frankly, I'll say this. Many of us feel that that particular provision of the law should have been repealed, and we think if the implementation of it had been called to the attention of the appropriate committees of the Congress in an adequate manner, it would have been repealed. By doing that, we would have taken out 100 pages of the manual. We would have made it possible at least for those claims people, who are spending one-third to one-half of their time administering an unsound public policy, to at least be released for some very constructive activity and to spend more time on direct service to the beneficiaries.

To me, that is also a part of the role of advocacy, and I feel that a Commissioner on Aging should keep in touch with the developments in a program of that kind which affects so directly the lives of 1.5 million older persons, and if a Commissioner on Aging spots the fact that there is an unsound public policy incorporated in the role, that the Commissioner along with others, inside and outside of government, should go to work on bringing about a correction.

Senator COCHRAN. Well, I'm sure that Commissioner Gwendolyn King and others at the Social Security Administration and in the Congress, too, appreciate the fact that she has named you as chairman of this advisory group to look into some of these issues and bring them to our attention in a way that will help serve as a catalyst for some change and reform that we really need in the system.

Thank you very much.

Dr. FLEMMING. Thank you.

Senator ADAMS. Thank you, Senator Cochran.

Thank you very much, Dr. Flemming, for an excellent statement. You have provided the foundation and the groundwork for the committee to now move ahead, and we appreciate your time and your testimony.

Dr. FLEMMING. Thank you, and I appreciate the opportunity of being with you.

Senator ADAMS. Thank you.

Senator ADAMS. Our next witness is Mrs. Betsy Follensbee. We are very pleased to have here with us this morning.

Mrs. Follensbee is a nurse by profession, and you will see from her testimony how her professional training and the caring that she has had for an unfortunate situation within her own family has given her first-hand experience with the ombudsman program, and

I hope will give us some critical insight as to the legal services problems and the advocacy problems that we have in these programs.

What I'm going to do, Mrs. Follensbee, is I have asked staff, rather than using elaborate lights and so on, to just let me know when there is about 1 minute left, and I will indicate that to you, and I'm not in any way trying to cut you off, but so we will be sure we hear everybody this morning.

Welcome to the committee, and we look forward to hearing your testimony.

STATEMENT OF BETSY FOLLENSBEE, PROFESSIONAL NURSE, LEBANON, NH

Mrs. FOLLENSBEE. Thank you.

I don't need to introduce myself because you have already done so. But I do speak as one who has received invaluable assistance and guidance from the services available to the aging and the disabled in the State of Vermont.

I have also had the opportunity to personally observe how the Long-Term Care Ombudsman program can be actually life-saving to one who has no interested family to care about him or her.

About 5 years ago, my brother was admitted to a Veteran's Administration Hospital in Vermont following a head injury received in a fall. After regaining consciousness, he had no memory for events of the last 25 or 30 years, and at present his memory span is about 2 minutes. He was transferred to a nursing home in Vermont by the social services of the Veteran's Administration Hospital.

Shortly after his admission to the nursing home, the Long-Term Care Ombudsman for the area, Mrs. Roberta Shippa by name, saw him while making a routine visit to that home. She spoke to him and realized that he could not care for himself or make an informed decision. With the aid of the social worker at the home, the Vermont Protective Services worker was asked to interview him.

A meeting was called which included persons from Vermont Protective Services, the Long-Term Care Ombudsman, and the Vermont Senior Citizens Law Project, as well as my sister and myself. We realized that one of his sons had been misappropriating his money and his other belongings, and we all agreed that my brother desperately needed someone to oversee his affairs.

I agreed to accept personal responsibility for him, although I had no idea what that would mean. Since that time, I have been guided through the necessary probate court hearings by Aurolie Jacques, the attorney for the Vermont Senior Citizens Law Project, and have received invaluable help from Mr. Patrick Flood and Mr. Mike Atley from the Office of Public Guardian.

My brother's care since that time has been constantly watched and helped by the Long-Term Care Ombudsman.

I have found that she is always available to assist me with any concern that I may have about his care and that she has the ability to interact with nursing service when necessary.

I could not have managed to carry out the duty that I had accepted without the help of the Long-Term Care Ombudsman, the

Senior Citizens Law Project, and the Office of Public Guardian, and their cooperation with each other.

Most importantly, I have become very aware that my brother could most likely have received substandard care, or even died, without them.

For example, the Long-Term Care Ombudsman recognized that my brother was not receiving all the nutrients that he needed. She brought this to the attention of the nursing home as well as to me, and he is now getting a daily nutritional supplement. On another occasion she recognized that my brother had very poor skin condition and that he needed special soap and shampoo, and he now has these items. Another discovery the ombudsman made was that he had a stitch abscess from some former surgery. As a result, my brother's infection was treated.

Along with all of these things, the Long-Term Care Ombudsman questioned why my brother was restrained in a wheelchair and diaper-bound. She consulted me and the nursing home about this, and I am happy to say that my brother is no longer restrained and is now walking with the aid of a walker. Now that he can get to the bathroom by himself, he has no problem with incontinence.

Beyond advocating that my brother receive an acceptable quality of care, the Long-Term Care Ombudsman helped my brother when the nursing home had him readmitted to the Veteran's Administration hospital, but then petitioned not to readmit him to that nursing home, claiming that he was violent and that they could not care for him.

By the way, he was admitted to the Veteran's Hospital for a medication adjustment, but he was also treated for two very, very bad decubitus ulcers and for the stitch abscess that still had not healed. Mrs. Shippa investigated this situation and learned that the nursing home had allowed his ex-wife, a nurse's aide, to provide care to him. They had a very unpleasant and painful divorce, and it was very upsetting for my brother to be put in such a vulnerable situation. At the same time, she cleared his name that he was not a dangerous person, but she recognized that he was not happy at that home and that it was probably in his best interest not to go back there. She stood up for him and helped keep the lines of communication open, and Mr. Atley from the Office of Public Guardian was extremely instrumental in contacting other homes.

So, happily, my brother now has been admitted to a different nursing home, and it is working out very well.

Senator ADAMS. You have 1 minute left, Mrs. Follensbee.

Mrs. FOLLENSBEE. Just one more sentence; I have to say it. I have been reminded by several social workers during these years of the great number of people who are dependent on these services just to survive, and I am convinced that they are life-saving.

I have been involved in the field of medicine for over 40 years, but the agents that I have met I am convinced are the most devoted and giving people it has ever been my pleasure to know.

Thank you.

Senator ADAMS. Thank you, Mrs. Follensbee.

I am very impressed with the fact that you are very appreciative of what has happened. With your experience, what do you think

would have happened to your brother if there hadn't been an ombudsman in this case?

Mrs. FOLLENSBEE. You have no idea how absolutely vulnerable he is and was because of the fact that he is living 35 years ago. He is about six feet, one inch tall, and he weighted 120 pounds—because if you put a spoon in his hand and give him some food, he eats two bits, and he forgets he is eating, you see. So if nobody says to him, "Eat," he doesn't eat.

He would have died, I am positive, because he was in limbo. The Veteran's Administration Hospital has what they call an "umbrella"; they send a person into a nursing home for 6 months under the Veteran's Hospital umbrella, and they have someone who sees this person once a month. But they are accustomed to seeing veterans who are in very poor condition, and when this is over, there is nobody. And he had not been declared incompetent.

Senator ADAMS. So if you had not been there and there had not been an ombudsman, he just would have died.

Mrs. FOLLENSBEE. He would have, yes. It was the ombudsman more than it was I, because of course, at least in the State of Vermont, or as far as the Veteran's Administration, you are not considered next of kin—his children were his next of kin. And his children were not interested once they realized he was helpless. There are people who don't care to be involved with someone who is completely helpless. And the son had appropriated everything he had, so there wasn't any reason to bother with dad.

It was a really terrible situation, and he would have died if the ombudsman had not recognized that he needed help. And I must say when they called in then, the legal services people and the other agencies, they worked so beautifully together to do this. And of course, I had absolutely no idea what it involved for someone to have to have guardianship and to be taken care of, and even now the ombudsman is invaluable.

Senator ADAMS. Senator Cochran.

Senator COCHRAN. Thank you, Mr. Chairman. I just want to join you in thanking our witness from Vermont for giving us the benefit of her experience in dealing with some of the services that are made available under the Older Americans Act. I think it is very clear from her testimony that these are sometimes very helpful and can be life-saving services. So it puts it in a human perspective that I think we ought not to forget as we proceed to review the Act and how we can make it even more helpful in the years ahead.

Thank you very much.

Mrs. FOLLENSBEE. Thank you.

Senator ADAMS. Thank you, Mrs. Follensbee, for your testimony. I agree very much with Senator Cochran—we too often place these matters in statistics or in legalistic terms, and it is absolutely essential they be placed in the human terms, which is where our interest really lies.

Thank you very much.

At this time, we will go to our third panel, which includes Ms. Trish Riley and Ms. Billie J. Marshall. I want to welcome our two witnesses, and I particularly want to thank Senator Cochran for assisting us in having Mrs. Marshall here this morning.

Just briefly, Trish Riley has had over 18 years of experience in the field of aging. She is a person upon whom we rely. She has had a wide range of experience and is presently President of the Center for Health Policy Development, a private, nonprofit health policy group, and I am just very pleased that she is here.

Billie Joyce Ware Marshall is a licensed social worker with 20 years of experience in the social service arena, and extensive experience in development and coordination and oversight of aging programs at the State and local level. She recently became involved at the State level while serving as the long-term care ombudsman for the State of Mississippi Department of Human Services, Aging and Adult Services.

As you can see, we are trying in the hearing this morning to outline the Act, the effect of the Act, and we now welcome the two of you to give us details as to how it is working.

Senator Metzenbaum has arrived.

Senator Metzenbaum, welcome, and we'd be most happy before starting with our witnesses to welcome you for an opening statement.

OPENING STATEMENT OF SENATOR METZENBAUM

Senator METZENBAUM. Thank you very much.

I cannot stay because there is an organizational meeting of the Judiciary Committee. But I do want to commend you for holding this hearing. It is a subject where you have provided great leadership, and I am very pleased to work with you.

This is the first series of hearings on the reauthorization of the Older Americans Act of which I am proud to be an original cosponsor. It provides a number of vital services to the Nation's elderly.

Your tireless and numerous efforts to improve quality of life for seniors is not a new subject around here. We all know you for it, and we respect you for it. And as a long-time advocate for nursing home residents and those who suffer from Alzheimer's disease, I look forward to this opportunity to examine how the Act presently protects the rights of the vulnerable elderly and what further steps we can take to strengthen this protection.

Although I won't be here, my staff is here, and I will look at the record because I am much interested in the subject.

I am also pleased, Mr. Chairman, to have the opportunity to acknowledge—and I hope I can introduce—an outstanding advocate for seniors who comes from my own home community, Dr. Georgia Anetzberger, who is the member of the fourth panel. She is the program director for the Western Reserve Geriatric Education Center and specializes in developing policies and programs against elder abuse. Her experience in developing Ohio's adult protective services makes her an extremely valuable witness, and frankly, I thank her for sharing her insights today and comment her for all of her efforts on behalf of the elderly.

My inability to be here is not due to a lack of interest but just a lack of time.

So thank you, Mr. Chairman, for proceeding forward.

Senator ADAMS. Thank you, Senator Metzenbaum. We welcome you here for as long as you can stay, and we do realize your other commitments. You and I have both had personal experience with

Alzheimer's, and it is one of the reasons why we have a deep interest in trying to be certain that we are protecting the vulnerable.

Again, with each of you, I will indicate when there is approximately 1 minute left, but don't feel that I'm trying to shut you off; if you have something more than runs over 1 minute a little, that's fine. I'm just trying to be sure we hear everyone.

Senator ADAMS. Why don't we start with you first, Ms. Riley, and then Ms. Marshall, we would like to hear from you.

Ms. Riley.

STATEMENTS OF PATRICIA A. RILEY, PRESIDENT, CENTER FOR HEALTH POLICY DEVELOPMENT, PORTLAND, ME, AND BILLIE J. MARSHALL, STATE DIRECTOR ON AGING, JACKSON, MS

Ms. RILEY. Thank you, Senator Adams, Senator Cochran, Senator Metzenbaum.

I very much appreciate the opportunity to talk about the Older Americans Act. Quite frankly, I think I didn't fully appreciate the value of the Act until I left the aging network and became director of an agency responsible for Medicaid, health planning, and licensing and certification of health facilities.

The Act's singular focus on and direction from older persons themselves and its responsibility to assure that elderly receive the full rights and privileges of society comprise its strength.

An agency like Medicaid, without such a clear client focus, can easily lose its perspective on the consumer amidst the competing demands to increase access for all clients, expand services, restrain costs and conduct claims processing.

Compared to the complex machinations of such a program, the goal of the Older Americans Act to protect an elderly person's rights unfortunately appears almost a luxury. Yet asking a society to recognize what a vulnerable older person wants and is capable of achieving, and assuring that person choice and self-determination no matter how vulnerable she is, ought to be the first test of a government program, not a luxury.

But such a role is contrary to bureaucracies which, by their nature, set norms, limits and standards. Still, it is the network's responsibility to change systems to reflect the needs of the elderly, and that responsibility is particularly important for the vulnerable, who may not be fully able to represent themselves in complex bureaucratic arenas.

But advocacy can become tokenism and paternalism, particularly if we assume to speak for elders without their voice. In large bureaucratic and political organizations like State governments, an agency's power and authority is measured not by its advocacy but by the size of its budget and scope of its authority. Without sufficient advocacy tools, the aging network is understandably drawn to the role of program administrator as a means to have more clout in system change and to be viewed as a peer among larger agencies.

Surely the network's leadership in developing home care systems bears witness to the efficacy of such an approach—and we did that in the aging network in Maine—but when you run a program, mak-

ing change is often quicker than gaining another agency's attention and convincing that agency to change.

Still, the difference between building a system and becoming the system warrants attention as we examine how best to protect the rights of vulnerable elderly. Of course, each State is different, and what works in one will not work in another, but the job of running a program is different from advocacy. If we are the system, who is our master? If we are the system, who will provide oversight and advocacy to assure that system reflects and represents older person? What will prevent us from becoming rigid bureaucracies like those we fight against today?

Conversely, if we are not the system, how will we make change happen?

The Older Americans Act can help State units retain their essential advocacy functions, particularly amidst the current State budget climate in which all but essential services are being eliminated, by insisting that States retain strong advocacy programs and by providing sufficient funds to State agencies, with sufficient discretion about their use, to support that advocacy.

The first tool of effective advocacy is sound information and good ideas, which represent the constituency. Thus, State units need sufficient resources to collect and share data and retain close communication with the elderly. Citizen advisory committees, public education, special studies, policy analysis, research and demonstrations all should be funded activities of State units on aging and are not today.

States today are engaged, as we all know, in drastic efforts to cut substantially their current services budgets. In a number of them, Medicaid medically-needy programs are on the chopping block, and Medicaid services are being slashed. In others, innovative home care programs are threatened and hospitals closed.

The network must be a "watch dog" on these systems and must provide reasonable solutions that meet budget concerns without compromising the vulnerable. But that takes staff and resources.

The network can also provide important outreach functions to assure that elderly receive the Medicaid benefits to which they are entitled. Recent Medicaid reforms have provided for presumptive eligibility for pregnant women and require that eligibility workers be placed outside Medicaid or welfare offices to encourage greater outreach to pregnant women and children. Similar provisions might be considered to encourage the elderly to participate in Medicaid. If elders did not need to wait for eligibility, delays in hospital discharge, and indeed, inappropriate nursing home placement, might be avoided, and service could begin more quickly.

But as important as outreach and securing eligibility to Medicaid is what Medicaid pays for, and the fight must continue by the aging network to redirect the Medicaid program to fund more home care and less nursing home care.

The ombudsman program can also play an important role in nursing home reform. Free from constraints of regulatory agencies are providers that can represent consumers not only on a case-by-case basis, but in system change.

The process of securing State approval to build or buy a nursing home is frequently extraordinarily and largely financial. But cer-

tainly as important to the decision of whether or not a nursing home can be financially viable is the quality of the care. Residents have little voice in determining which nursing homes are authorized and licensed, but their ombudsman, if research is carefully and skillfully done, can and should intervene.

Currently, most State agencies on aging address some or all of these issues to some degree, but their capacity to truly assure the rights of the vulnerable elderly is too often limited by insufficient resources and inadequate flexibility in how they can be used, unclear goals and expectations regarding their advocacy mission and insufficient technical support and assistance.

Senator ADAMS. You have another minute, Ms. Riley.

Ms. RILEY. The proposal to establish a separate authorization within the Act to give States the ability to enhance their unique role as advocate of elder rights deserves support. As State budgets are cut, the network must be the guardian of the good for all elderly, particularly the most vulnerable. To do so requires the consistent capacity to analyze a variety of public and private programs and policies and to document problems and propose solid solutions. That requires tools, resources and unshakable Federal support.

I would urge you in this reauthorization to further your support of this advocacy role and the establishment of a separate section in the Act to support it.

Thank you.

[The prepared statement of Ms. Riley appears in the appendix.]

Senator ADAMS. Thank you, Ms. Riley.

Before turning to Ms. Marshall, I am going to ask that a chart be put up, which I will ask some questions about on your last point that you made.

Also, while that is being done and before we proceed with Ms. Marshall, Ms. Riley is Senator Mitchell's recent appointment to the Federal Council on Aging, and I understand the entire Council is here because they are meeting in DC this week. So if they are here, I would appreciate their standing so I could see them.

We are pleased to have you all here, and the committee welcomes you. We are pleased that Ms. Riley has testified and that you are here, and you are helping. We wish you very well during the course of the week.

Thank you.

Senator COCHRAN. Mr. Chairman, could I express a special word of welcome to my constituent from Mississippi, Ms. Marshall, who is on this panel?

Senator ADAMS. You certainly may.

Senator COCHRAN. I just want you to know, Mr. Chairman, what a fine asset she is in our State and also how she has been helpful to this committee in the past. We had a field hearing in Meridian, MS last February, and Ms. Marshall was one of our star witnesses. She has had a lot of personal experience as an ombudsman, and she currently serves, as you observed, as State director of our Council on Aging in Mississippi. And she does a very fine job.

So I am very happy she could be here with us today and help in this initial hearing on the Older Americans Act.

Thank you.

Senator ADAMS. Thank you.

Ms. Marshall, we are very pleased to have you with us this morning, and we are looking forward to hearing your testimony.

Ms. MARSHALL. Thank you.

Mr. Chairman, members of the committee, I appreciate the opportunity to be here, and thank you, Senator Cochran, for your kind remarks.

I'm just going to go straight through to the third section of my remarks, on the second page, and start there in terms of summarizing what I have written.

As an older person attempts to access needed services, the problem or potential for a problem comes when he or she has to rely on another person or institution.

If one has to rely on an institutional system such as Medicare or Medicaid for basic health care, the system itself can become abusive as it attempts to ration limited funds among the beneficiary population. Rigid policies and practices frustrate the beneficiaries because they can be too complicated to easily understand and because they can be too rigid and inflexible in unique situations.

Whether objectively justifiable or not, those frustrated beneficiaries often feel that the system simply is not just. If one has to rely on an institution such as a nursing home or even in-home providers for assistance in merely surviving, that institution can become abusive by virtue of its need to survive financially. The payment is often insufficient to purchase the kind of care that would be more responsive.

The institutional setting itself, even when there is no intention to abuse or neglect, can cause grief and anxiety among those it is designed to benefit.

If one has to rely on family members, friends or others in the community for assistance with finances or life decisions, there are opportunities for abuse.

Some of that abuse may be intentional, but much of it comes from the frustration that the assistance giver feels in his or her inability to cope with the responsibilities that go along with giving assistance.

All efforts to deal with the rights of the elderly should look closely at the very basis of how well we care for the elderly in our society. If we build systems that abuse, then abuse can be expected. If we can build systems that nurture and provide, then that kind of system is more likely.

An example that comes to mind to me—and this is a true situation—is a claims examiner who may be looking at the claims papers for Medicaid/Medicare or even private insurance, and rather than the claims examiner looking at how he can help that older person to benefit from the program, what he tends to do is look at what ways he can deny that benefit. The benefit is granted if he doesn't find any disqualifying conditions, rather than trying to give the older person the benefit from the beginning.

I think what the aging network has to be about is finding ways to do the opposite. We need to look for ways to get an older person what he or she needs to live with dignity and independence. When that kind of care system is established, it will not be necessary to attack the system to force it to do what it is supposed to do.

Given these life realities, the recommendations that we will be making from our office to help strengthen the Older Americans Act are listed on page 12.

First, we feel that a title should be established which encompasses advocacy, rights and entitlements, protective services, counseling, legal assistance and ombudsman activities for in-home as well as institutional care.

The amendments should contain stronger statutory provisions to target the old-old, low-income minorities and rural citizens.

The funding formula to States should reflect individual State demographics just as States must use in their intrastate funding formulae.

Much more focus should be placed on collaborative efforts with other relevant Federal-level agencies in serving older citizens.

Stronger language should be added to encourage the development of private sector/aging program relationships.

Programs should place more emphasis on support services for family members and caregivers who provide voluntary assistance to frail, vulnerable and homebound older persons.

More attention should be given to information and referral, outreach, public information and public education.

I think in order to achieve this we must adequately fund the Older Americans Act, especially the new suggested title for elder rights and advocacy.

Let me close by giving you an example of one of the issues that I had to face as I became State unit on aging director. We in our State look with a great deal of pride on the number of meals that we serve older persons, and I think it is important that we do that. We are very proud that we are able to provide those kinds of services. But at the same time one of the issues that I have been looking at is if we serve five meals or five congregate meals to elderly people, what then have we done as a State unit on aging to impact on the lives of older people for those other 16 meals; what changes have we made in our system to ensure that their rights are protected? What changes have we made in their lives in terms of advocacy so that they can access the kinds of services and needs that they themselves have?

So I think we must look beyond just being able to provide those specific services, but we must be able to provide opportunities for change, not only change as far as the older person is concerned himself, but change as far as his ability to access the services that he needs.

Thank you.

[The prepared statement of Ms. Marshall appears in the appendix.]

Senator ADAMS. Thank you, Ms. Marshall. I was particularly taken by and believe in the comment you made that an institution with a claims officer—and this happens throughout all of our society—tends to look not at what can be done to help the person that is there, but at what can be denied.

The reason I put this chart up is that I have a question for both of you, and either or both of you can comment on it. What this chart indicates is that for the first time we have funded—and I know it is hard for you to see it, but I'll give an example from the

State of Mississippi for example—we did for the first time in fiscal 1991 fund this program for prevention of elder abuse, which is maybe the wrong word to use, but it is to be friendlier and more fair, what you are talking about, and what some of the other witnesses have talked about, actual cases of where people have had funds misappropriated or been abuse.

But we only appropriated \$2.9 million, and according to the administration, apparently this is to be distributed to each of the 670 agencies. And when this is divided among the 57 States and Territories, it represents very small amounts of money, and that is what this chart gives some indications of.

For example, the State of Mississippi really receives \$30,280 for this. Now, my question is this. Is automatically dividing this 670 ways the best way to spend the funds, and whether it is split 57 or 670 ways, can this money have an effect, and if so, in what ways?

I guess this is the classic question in taking care of our people in America today—you've got so much money, and how do you spend it best?

Ms. Marshall, you might want to start, since we have Mississippi up there.

Ms. MARSHALL. Certainly, there is not a best way to divide a small amount of money any way you look at it. What we have done in our State is to make an effort—and this money came at a very opportune time. In my comments I mentioned that in our department we have adult protective services as well as the State unit on aging, and we have been charged with the responsibility in our division, aging and adult services, to develop a comprehensive program that will look at adult protective services, be it the older person in an institution or be it the older person in a noninstitutional setting.

So we are going to be using those limited funds to help us incorporate that and to ensure that we can do all kinds of public education on the rights of older people, ensuring that their caregivers know what the rights are, also ensuring that the community in general as to what the needs are. Certainly, this is an opportunity to begin a program that needs to be expanded in the future so those funds, although not a lot, will be utilized to the fullest dollar for dollar.

Senator ADAMS. Ms. Riley, do you want to comment on that?

Ms. RILEY. I think I'm in a lucky position no longer working in the network, that I have a different perspective. While I am a supporter of area agencies on aging and think the fact that they are independent, and that tension that exists between the area agencies and the State is terribly important to advocacy, the reality is that the State have very little clout and very little discretionary dollars with which they can act.

Without that, if they must always allocate dollars out to AAAs, they really have no clout at the State level to do the research, to do the kinds of advocacy programs suggested here.

For example, the earlier testimony from Vermont was really shocking to me as somebody who used to run a licensing program. We can spend money having people investigate complaints like the previous witness talked about. The real question that was begged

in her presentation was what is going on in that licensing agency. States need the kinds of resources at the State level to be able to impact on departments of health to make sure that people like her brother have secure systems so that that problem doesn't arise.

She shouldn't have had to move her brother from that facility. That facility should have changed. But if you are always funding little, tiny parts of the problem—investigators at a local level—and I'm not sure I know enough about this particular initiative to know what kinds of activities go on—you lose the resources at the State level that are very important to system change.

So I guess the short answer is that States need some flexibility in resources if they are really going to engage their peers, their sister agencies, in change.

Senator ADAMS. Senator Cochran.

Senator COCHRAN. Thank you, Mr. Chairman.

I have been impressed with the testimony of our witnesses on this panel because they both have experience in helping manage inadequate funds to try to deal with huge problems.

I wonder whether or not in our effort to assess how much should be earmarked or set aside in an inflexible way for certain activities, such as legal services, for example, if we are depriving local administrators of the flexibility that Ms. Riley just described is needed to make sure that the program is suited to local needs.

For example, if you have an attorney general, like some States do, who is very aggressive and who goes out and actually takes on some of these problems in class action lawsuits or other kinds of actions, to try to be an advocate for the vulnerable elderly, or if you have private lawsuits that are filed against institutions and recoveries are obtained and examples are set, couldn't you make a judgment at your State level or at maybe a local area level that the exact amount of money allocated for legal services may not be needed in that situation because of other things that are happening, and maybe the needs are greater in another area?

What is your reaction to that?

Ms. MARSHALL. We have been grappling with that for a long time in our State. Of course, we want to leave to local administrators and area agencies on agency the flexibility to adjust their budgets and have certain percentages of money allocated for legal assistance and ombudsman and other kinds of programs. But I think what happens is that if we're not very careful, we make assumptions that an area has sufficient dollars or has sufficient support, when in actuality, when older people begin to try to access the services, we find that it may be there but it is not practical in terms of their needs, it is not implemented practically.

That's why I think it is important as Trish was saying, that States have some responsibility to ensure that moneys are spent to provide adequate services. I would hate for us to get into the position of saying that an area agency or local program should spend one percent or 2 percent or three percent of their funds for legal assistance, because if we do that, I think what happens is we say that that's all that is needed, and we don't leave room for situations where that probably is not enough.

What I think we have to do, then, is working between States and area agencies on aging to look at what is available in that particu-

lar district, how are people accessing the system there, just what is available from the State level, how that is being accessed, and then make that kind of determination by State with the local program, rather than talk about a percentage of money for a particular area or a particular issue.

I think we need to have a minimum amount of money, but we need to look beyond just assigning dollars as much as determining what the needs are, and then accessing, and then looking at how much that is going to cost.

Senator COCHRAN. Ms. Riley, I'd be interested in your reaction to that.

Ms. RILEY. I think it is a difficult question particularly in light of the current State budget situations. The reality is, in tough times like this, the Older Americans Act competes less well with compelling, direct service program. It is very difficult to make the case for advocacy in a time of budget cuts—if it means putting food on the table, if it means getting day care for a child, if it means protecting vulnerable persons in a way that is a direct services, compared to advocacy. Advocacy is the first to go.

If there isn't clear protection in the Older Americans Act, indeed that is exactly what happens. So while I don't think there ought to be earmarks about how much money ought to be spent and I think your example of an attorney general who is aggressive is an excellent one—we do need to have some kind of standards that I think don't exist today about what we mean by protecting rights of vulnerable elderly. We really have no good indicators. The indicators we use are how much money we spend, which is probably the worst indicator.

I think, and I wrote in my testimony, that we might want to have a national report by State and by area agency on aging on how effective we are in meeting standards that translate to caring for the vulnerable elderly. I don't know what those standards are, but I think of the Children's Defense Fund and their excellent work in publishing a report card on the status of children in America. Every newspaper picked up the fact that we lead the world in infant mortality. Every State knows where it stands. We know this is a serious crisis.

I think we need a similar set of standards—they are difficult to develop and difficult to measure—that would more appropriately and effectively move us down an advocacy trail than simply determining how much money needs to be spent.

But the Older Americans Act has to protect the advocacy function somehow and with some language or it will be lost.

Senator COCHRAN. Thank you very much.

Thank you, Mr. Chairman.

Senator ADAMS. Thank you, Senator Cochran.

Thank you both very much for excellent testimony and in particular in the advocacy area and what the States are doing and the problems they are having.

The fourth panel will deal with some questions you raised about advocacy and how effective or not effective it can be and where it should be.

I'd like to call first Mr. D. Ty Duhamel—and I have got to pronounce your name exactly right since you are from the State of

Washington. I am a very great advocate of the Evergreen Legal Services. In fact, one of the former directors we hired when I was in private practice to be administrator of the law firm. This is a very usual and wonderful advocacy group for all types of people who need legal services in the State. I am very pleased that you are here this morning to testify about that.

Patricia Lashway is current with the Office of Consumer Affairs in the Nursing Home Services Division, also of Washington State. We are proud of our program there just as you are, and I welcome the two of you as witnesses today.

I am also very pleased to welcome Ms. Georgia Anetzberger, program director of Western Reserve Geriatric Education Center, from Cleveland, OH. As I understand it, she is an assistant professor at Case Western University in Ohio. We are looking forward very much to your testimony.

And finally, Michelle Holzer, who is coordinator and senior health insurance counselor and advocacy program director for the Maryland State Office on Aging.

As you can see, this panel now is dealing with the actual services that are performed. I will give each of you a minute's warning before the end of your testimony, but as I said, I don't want to cut anyone. I want you to have a full opportunity to do this.

We'll start with Ms. Holzer and move down through the panel, and then we will question the panel after you have all had an opportunity to make remarks, and if you wish to criticize somebody else's remarks, that's fine by both of us.

Senator COCHRAN. Except for the members of the committee.

Senator ADAMS. Yes; we're both very tender up here, as you might well imagine.

We are pleased to hear from you, and we welcome you all to the committee.

Ms. Holzer.

STATEMENTS OF MICHELLE HOLZER, COORDINATOR, SENIOR HEALTH INSURANCE COUNSELING AND ADVOCACY PROGRAM, MARYLAND STATE OFFICE ON AGING, BALTIMORE, MD; D. TY DUHAMEL, DIRECTOR ATTORNEY, EVERGREEN LEGAL SERVICES NORTH CENTRAL REGIONAL OFFICE, WENATCHEE, WA; PATRICIA K. LASHWAY, CHIEF, OFFICE OF CONSUMER AFFAIRS, NURSING HOME SERVICES, DEPARTMENT OF SOCIAL AND HEALTH SERVICES, OLYMPIA, WA; AND GEORGIA J. ANETZBERGER, PROGRAM DIRECTOR, WESTERN RESERVE GERIATRIC EDUCATION CENTER, CLEVELAND, OH

Ms. HOLZER. Thank you, Mr. Chairman, Senator Cochran, and good morning.

I appreciate this opportunity to discuss with you the inclusion of protection of consumer rights as related to the reauthorization of the Older Americans Act.

As coordinator of the Maryland State Office on Aging's Senior Health Insurance Counseling and Advocacy program, SHICAP, I see the need for the inclusion of health insurance claims assistance, counseling and advocacy programs as a mandated service in the Older Americans Act as an essential element to help secure the

consumer rights of seniors in this country with regard to Medicare and other health insurance issues.

Sufficient resources must be allocated to carry out this program. All too often, the seniors in our country do not understand the benefits and limitations of the Medicare program nor their supplemental health insurance or medigap policies. They are subject to pressures placed on them by insurance agents, who prey on their fears and often convince them to purchase more insurance than they need or to replace perfectly adequate existing policies. They succumb to the many unscrupulous tactics and practices fostered by some insurance agents and companies.

Many seniors are unable or unwilling to submit or follow up on their insurance claims, resulting in millions of dollars of uncollected benefits in the hands of insurance companies, and not to our seniors, many of whom are already living on a tight, fixed income.

In some cases, it is a choice between proper nutrition, their prescription drugs, and paying the doctor. Oftentimes, the doctor gets paid first.

For many seniors, it is just too difficult to handle the Medicare and medigap maze they must deal with in order to collect their benefits. They would rather just pay the bill than to get involved with burdensome paperwork and bureaucracy.

This is especially true if the claim is disputed and gets to the reconsider or appeals stage; the senior would often just pay the bill than to become entangled in a hearing or court case.

Seniors are extremely fearful when a bill goes into collection and they start to get threatening letters from collection agencies. They have always paid their bills on time and are not used to harassment from bill collectors. This harassment is indeed a pity, especially when the senior has been paying on an insurance policy that happens to be slow in paying or is balking at paying a legitimate bill.

Our clients often need to be empowered to exercise their consumer rights. Our seniors have the right to question their doctors about not only their condition and treatment plan, but also the financial cost to them. They have the right to request their doctors to accept assignment, particularly if a financial hardship will result.

Many physicians will accept assignment if approached, but their senior patients are often hesitant to ask for what they feel is charity.

Seniors have the right and responsibility to fully understand their Medicare and medigap coverage and to get clear answers to their questions. They have the right to get their bills submitted to Medicare on a timely basis. All too often, a senior is requested to pay a bill up front when a doctor does not accept Medicare assignment, and then the physician has a year to submit that bill to Medicare, and the senior may have to wait quite a while for reimbursement.

Seniors have the right to get speedy and courteous service from Medicare and medigap representatives. They have the right to make insurance purchase decisions without harassment and pressure, and with full disclosure regarding the benefits provided, service limitations and exclusions, right to review, right to cancel, "free

look" provisions, options available, and rate structures. They have the right to be able to read through their insurance documents and contracts in large enough type, prior to making a decision. They have the right to fully draw upon their benefits without arbitrary and capricious restrictions.

Seniors also have the right to fully exercise all protections available to them and to access those agencies involved in regulating and licensing providers of medical care and/or the insurance industry.

I'd like to briefly outline how Maryland has addressed this issue most successfully. The Maryland Office of Aging's SHICAP program has four main elements: claims handling—we get those shoeboxes and shopping bags full of claims; one-on-one counseling; legal and informal advocacy, and public education.

Our program is presently operating in 14 of 24 jurisdictions, by State grants to 11 area agencies. We rely primarily on training volunteers to provide these services. We are one of 11 programs at this point recognized nationwide as a leader.

I have provided information in terms of some statistics on our program.

We feel that State units on aging sponsored health insurance claims and counseling programs complement other State and local services by acting as the "eyes and ears". We are able to reach out to large groups of seniors in a nonthreatening environment, utilizing peer counseling and assistance, including home visitation, as necessary.

Mr. Chairman, I urge you to consider the inclusion of health insurance claims, counseling and advocacy programs, with sufficient resources to carry out the program, as a mandated service in your deliberations and with respect to the reauthorization of the Older Americans Act.

Protecting the consumer rights of our vulnerable senior citizens should be an essential part of services provided through the established aging network.

Thank you for this opportunity to present to you today.

Senator ADAMS. Thank you, Ms. Holzer.

[The prepared statement of Ms. Holzer appears in the appendix.]

Senator ADAMS. Mr. Duhamel, I want you to know how much we in the State of Washington and also the State of Michigan appreciate the litigation that you have carried out for seniors during the course of your career, which has had a significant impact on the rights of our senior citizens. I want the panel and others to know that you are here not only as an advocate, but we want to express our gratitude to you for having done that.

We're prepared now and interested in hearing your testimony.

Mr. DUHAMEL. Thank you very much for those fine and wonderful words. I appreciate it.

I work, as the Senators has said, for Evergreen Legal Services in the State of Washington. I am in the North Central Regional Office, a rural area that encompasses six counties which geographically are the size of Connecticut.

We do outreach. We have a 1-800 phone line. We visit seniors in their own homes, in nursing home. It is a very big area. We have approximately 35,000 seniors living in the area, and we only have

three attorneys in our office. And we have an obligation, of course, to serve women, children, disabled people and senior citizens.

What we try and do is allocate approximately two-thirds to three-quarters of one attorney's time to senior citizens. And I don't use that for purposes of illustrating an illustration, but just as an illustration of how limited our resources actually are.

What I wanted to do today is basically explain what kinds of services we offer with that money because it is most important that we deliver the kinds of services that have the most beneficial impact possible on the vulnerable elderly.

Three components to our services are direct services to seniors, training to private bar members who might serve the elderly, training to lay advocates who might serve the elderly, and outreach and community education activities to make people aware of what their rights are so they can enforce them.

By way of direct client representation, just to give a few examples of what we do, in this last year of 1990, we represented a series of clients which I think illustrate well the value of legal services. We had one 68 year-old senior citizen who could not prove his age, and so when he went in to apply for supplemental security income benefits, the benefits were denied. Legal services was able to provide the necessary representation to secure appropriate documents that enabled him to prove his age and receive benefits. Of course, his limitation and ability of being able to prove his age was as a result of his mental incapacity and also the destruction of his records during his lifetime.

We represented another client who as a ward. He was in his 80's. He had \$92,000 stolen by his guardian. His guardian had stolen seven consecutive Social Security checks. This individual lived independently, had a mental incapacity, and his landlord brought him down for assistance. We were able to secure the return of his Social Security checks; the \$92,000 was gone.

We have had problems with medical assistance. We represented four vulnerable seniors, living in their own homes, who have had essential home health medical benefits denied or terminated during this last year. I am not particularly happy to report that there is a difference in my view in application of Medicare home health rules between fiscal intermediaries, and when a fiscal intermediary denies payment of essential home health services, an attorney is appropriate.

In terms of housing, we represented an 86 year-old nursing home resident who was inappropriately in the nursing home and needed to be in her own home. She applied to public housing and was denied public housing on the grounds that she was mentally ill—in direct violation of the 1988 Amendments to the Fair Housing Act.

We also provide legal assistance in helping vulnerable seniors secure safety and independence. The growth of drug usage in this country has had a dramatic impact on the senior population. Our office has represented two seniors in the last year who were being victimized by cocaine-addicted children who had moved into their home, stolen their assets and money, taken their vehicles, and in one case was actively selling cocaine out of the senior's resident, and when the senior protested he was told to "Shut up, or I'll fix you."

We had one other case of abuse where a child was stealing a senior's assets and using the money to go to Hawaii and to Alaska for trips and vacations, and when questioned about the appropriateness of her involvement she replied: "Whenever my mom protests, I slip her a mickey."

We have a vulnerable adult protection statute in Washington, which I think is a very valuable tool to protect the vulnerable elderly, that enables them to get a restraining order against people who are abusing them. Attorney services are necessary to that end.

In terms of training, our information and assistance program advocates on behalf of low-income people. For example, we have trained them, we have told them how to negotiate, how to investigate, we have taught them landlord-tenant law, and they effectively go out and talk with landlords when disputes arise and attempt to solve problems. If they cannot solve the problem, they refer the case to us, and we handle it.

For example, this year we had a case where a woman fell, broke a bone, went into a nursing home, and the landlord packed up all her belongings, moved them out into the garage, had started painting her residence and advertising the vacancy. He wanted to move someone in and charge more rent. This senior who wanted to return to her home had lived there for 15 years.

Lay advocates are also able to represent vulnerable seniors before administrative agencies—State welfare agencies, the Social Security Administration—handle Medicaid cases, handle Medicare cases. We train them to do that. There are limitations on what they can do, though. If there is a significant legal issue, they really don't have the expertise to do the representation. If they lose, legal services offers the appeal, and if it is a case involving very significant benefits, they also have difficulty doing the representation.

Our private bar is very generous in increasing pro bono efforts to seniors and to others. We provide training to the local bar association and to State bar associations in the way of continuing legal education seminars on such subjects as Medicaid and transfer of assets, and different legal areas which affect the elderly, and in some cases they are more than happy to volunteer their services in exchange for such training. But it does require the commitment on both ends, both from someone to train and someone to offer the services at the end.

In terms of outreach and community education, we provide speeches whenever we can, addressing Alzheimer's groups, Alliance of Mentally Ill groups, senior citizen groups, do newspaper articles on recent developments in the law, and provide the education, the material and information which enables seniors to both understand their rights so they can protect themselves from pitfalls that might lie before them and which also helps them identify when they might need legal services.

Thank you very much for this opportunity to present testimony.

Senator ADAMS. Thank you very much. We will be back with questions in a moment.

[The prepared statement of Mr. Duhamel appears in the appendix.]

Senator ADAMS. Ms. Lashway, it is a pleasure to have you here from the State of Washington. I know that you have been very ac-

tive in the Puget Sound Services for the Aged, and we are looking forward to hearing your testimony on representing senior citizens, because I think it is important that nationally we understand that efforts are being made within the States, but how difficult it is and how vulnerable the elderly really are, and often to those who are closest to them. So we appreciate very much the testimony we have just heard, and we look forward to hearing yours, Ms. Lashway.

Ms. LASHWAY. Thank you, Senator.

My comments come to you after several years of working as a legal services attorney in Tacoma, WA. I left there and went on to be the State legal services developer for the State of Washington and was doing that during the time of the minimum percentage struggle, and have left that position and am now working with nursing home services in a consumer affairs unit which handles a lot of the complaint resolution and looks at a lot of the issues of integrating the demands of OBRA with a quality assurance program.

So my comments are going to be basically in two categories. One is about the language around the legal assistance piece of advocacy, and then I am going to follow that with some emerging ideas about OBRA and the possible role of the area agencies on aging in quality assurance within nursing homes.

The minimum percentage funding policy that was mentioned before, while I too was not a particular advocate of that tool, certainly gave us an opportunity in the State of Washington to really look at legal assistance and what is available to seniors and what problems do exist for seniors. And along with the Washington State Bar Association and legal services and the area agencies on aging, I think we did a fairly comprehensive look at where the gaps were and where the problems were.

We went to the State Council on Aging, which is an advisory group to the governor, and asked them for their assistance in coming up with a minimum percentage. That group worked quite hard at assessing what was in the community and making a recommendation back to the State unit on aging.

What they found in the most part wasn't a surprise to us. They found that seniors' needs were in survival issues, housing, food, health care representation. They found that seniors for the most part were not willing to show up at priority-setting engagements at the area agencies on aging, and therefore they weren't very well-represented in those priority-setting processes. They also found that case managers throughout the State of Washington were by and large the strongest advocates for increased funding for legal assistance, and that came as a very large surprise to a lot of people.

But to follow up on what Ty offered, I think the reason for that is somewhat self-explanatory. Our case managers are in the field; they see seniors; they want to understand legal issues, they want to understand that there is a legal solution to their client's concerns, and they want to know when it is appropriate to refer that person to someone with some legal expertise. And they also want to know when it is that they might have the skills that they could represent that senior at a fair hearing or in an application process.

Wherever along that continuum, case managers stood out as the strongest supporters for increasing that funding.

The State council came back and recommended a phase-in which now has brought us to 11 percent funding in our State. And again, not necessarily being in support of that mechanism, what that has done in our State is that it has stabilized funding for legal assistance in our State and has allowed the III-B providers, the sub-contractors, to actually leverage more money from United Way and from other fundraising groups to increase services to seniors.

So we have not only gotten an increase in services in areas that were delivering services under that percentage, but also in some other areas, from other sources.

As a result of some of the concerns that came out of that process, I would recommend to you and have summarized a list of recommendations. One is that when you are looking at the language of the statute around the legal services developer, I would really recommend that you look at some language that requires the State to have someone in their State system who at a minimum looks at the development and coordination of legal assistance delivery models; also, someone who will look at State advocacy and training and someone who will look at and deal with the development of private bar efforts to represent seniors.

I also would hope that you could strengthen the definition by requiring that Title III-B legal assistance providers must provide court representation where appropriate.

I also would hope that you would consider language that would define the types of cases that at a minimum must be dealt with within the Title III-B funding such as food, housing and health care issues.

I also would hope that you would consider some language that would clarify and further define the standard through which State agencies could grant a waiver from the minimum percentage funding requirement.

Advocates within the aging network should not stop their advocacy at the nursing home door, and I think it is the experience of myself and my colleagues throughout the country that the aging network does stop a lot of their advocacy at the nursing home door. OBRA has given us an opportunity to look at quality assurance in nursing homes in a way that we have never looked at it before. I would hope that we could look at that reauthorization as an opportunity to require integration and working agreements between the ombudsman, adult protective services, any quality assurance program that exists within the State, nursing homes and otherwise.

I would hope that there could be some language that would address the issue of requiring area agencies on aging and State units to include residential and nursing home residents in their priority-setting process. The process must go out to those people; the people cannot come to it.

I would also hope that case management would be allowed to expand and to begin to think about their role in nursing homes, in helping people to get rehabilitative services and move back out into the community.

I would encourage the network to look at nursing homes as a part of the long-term care continuum, not as a place where people

go to die. OBRA has spoken to us about residents' rights and about the need to educate resident councils, families and other members of the community. I would hope that the aging network would rise to that and participate in quality assurance programs and participate in furthering the rights of seniors in those settings.

Thank you, Senator.

Senator ADAMS. Thank you very much, Ms. Lashway, for that excellent testimony.

[The prepared statement of Ms. Lashway appears in the appendix.]

Senator ADAMS. Ms. Georgia Anetzberger, we are very pleased to have you here with us this morning. You will be the last witness on our panel.

Ms. ANETZBERGER. Thank you, Senator.

I was introduced as the director of the Western Reserve Geriatric Education Center, and although that is true, I would also like to indicate that up until about 6 months ago I was the executive director of the Western Reserve area agency on aging, which represented a constituency of older people in excess of 370,000, including large numbers of minorities and large numbers of low-income individuals.

Mr. Chairman, Senator Cochran, I'd like to thank you for the opportunity to speak today on the rights of vulnerable elderly and how they are protected within the context of the Older Americans Act.

I'd like to start by acknowledging and supporting the contributions the aging network already makes in this area, focusing my remarks on the problem of elder abuse particularly in the State of Ohio.

The Ohio aging network is active in abuse prevention and treatment in several ways: problem identification and investigation, direct services, community education, program development, and service linkage.

More specifically, about 10 percent of all elder abuse reports come from workers at senior centers, nutrition sites, and offices on aging. In daily contact with older people, these individuals are critically situated to observe changes in their behavior and appearance, and report any suspicion of elder abuse that arises.

Although Ohio's Adult Protective Services Act places responsibility for investigation of elder abuse on county departments of human services, occasionally county departments delegate that authority to other agencies. In Cuyahoga County, six agencies have been designated as having authority in investigating abuse situations that come to their attention including some in the aging network such as the Lakewood Department on Aging and the Long-Term Care Ombudsman Program. This system works well, and I would emphasize it because it reduces the number of agency contacts that victims have and increases the likelihood of swift action to address the problem of maltreatment.

However, perhaps the greatest contribution of the aging network rests on the vast array of resources it offers to abused elders and their caregivers. Older Americans Act services such as home-delivered meals, legal assistance and personal care go a long way in im-

proving the situation of victims and removing the factors that contribute to abuse occurrence.

The other aging network roles in abuse prevention and treatment rest largely with area agencies on aging, State units on aging, as well as the Administration on Aging. These organizations help educate professionals as well as the public on elder abuse as a social problem, such as in Ohio through workshops at the Multidisciplinary Institute on Aging and the annual governor's conference on aging. These organizations also encourage the development of related innovative programming like the recent Administration on Aging-funded guardianship diversion program in Trumbull County. And these organizations also promote service coordination. In northeast Ohio, for instance, the Western Reserve area agency on aging serves as auspice for the protective service consortium for older adults, which is a network of 80 organizations attempting to deal with elder abuse in our five-county region.

Yet despite the considerable activity and concern of the aging network in elder abuse prevention and treatment, it has simply not been enough. More importantly, it is often misguided and fails to respect the rights of vulnerable older people.

Let me illustrate. Representing the protective services consortium for older adults, I have attempted to offer public testimony and public education on elder abuse at senior centers and nutrition sites, frequently only to be rebuffed by their coordinators, who are more concerned about arousing fear among participants than assuring that these participants are aware of a problem that potentially could affect them as well as their friends.

Other times, the aging network has moved toward the use of restrictive legal and service interventions prematurely. For example, a while back, the Federation for Community Planning of Cleveland surveyed service providers to identify disorders that were regarded as indicators of the need for guardianship. The findings included arthritis, bone fractures, amputations, and incontinence, none of which would seem to reduce somebody's ability to handle finances or decide proper medical treatment. However, for some service providers, they offered a rationale for guardianship.

Similarly, while employed as a consultant in adult protective services to our local county department of human services, I found some in the aging network promoting the safety of older people over their right to self-determination, including the right to elect to live where they choose, even in dangerous situations, if they were competent to make that decision. The hue and cry from the aging network at such times was "do something, no matter what."

It seems to me that with Older Americans Act reauthorization, we have an opportunity to take stock and refocus, to challenge some of our traditional ways of operating. In this regard, sometimes it seems that in an attempt to fulfill our advocacy function, we in the agency network infantilize the aged and remove from them the right of autonomy and decisionmaking. Other times, in fulfilling our service provider function, we curtail the ability of older people to refuse services, often using subtle methods of cajoling them around service receipt.

And finally, sometimes in our attempt to build a service delivery system, we reduce the element of choice in service delivery, limit-

ing the number of agencies funded to provide specific services and reduce the ability of consumers to select services that meet their standards of quality, although perhaps not ours.

I suggest that the aging network needs to raise its own consciousness about individual rights and reaffirm adherence to American cultural values around freedom, independence and individualism, and recognize how these values can become circumvented through paternalistic service provision.

A bill of rights for vulnerable aged should be included in the directives surrounding the provision of all Older Americans Act services, and protection of these rights should be monitored by every area agency on aging.

I believe that to do otherwise fails to recognize older consumers as adult citizens, which they are, and continues to define "advocacy" to mean "resource pusher" rather than "rights promoter".

I'd like to leave the subcommittee with two examples of bills of rights that have been developed in the State of Ohio. One of them deals with impaired older people generally; the other specifically deals with adult protective services. They can provide guides in your deliberation.

Thank you very much.

[The prepared statement of Ms. Anetzberger appears in the appendix.]

Senator ADAMS. Thank you.

I'm going to let Senator Cochran question first, and I'll be right back.

Senator COCHRAN. Thank you, Mr. Chairman.

I think this panel has provided us a lot of insight into some of the reasons why it is important for us to consider advocacy and legal services as a part of the mission of the Older Americans Act in terms of encouraging its availability and providing some resources to help support those services.

I am curious as to how much of an impact it would be as a practical matter if there were no Older Americans Act funds available to support these services. In SHICAP, for example, Ms. Holzer, how much of the budget would be lost if Older Americans Act funds weren't available to you in that agency?

Ms. HOLZER. Right now, our program is solely State funded to the tune right now of \$166,00 which at this point serves 14 of 24 counties in Maryland. Some of the local area agencies on aging do match the fund, but generally it is a very soft match—in kind service contribution.

The Maryland State budget right now is in a difficult situation, and we are presently looking at perhaps as much as a 25-30 percent decrease in SHICAP funding at this point, which is truly a pity.

Some of our counties are funded at the \$3,000 level, and in some cases, by some of my case examples, for a single client we have saved as much as \$1,000, \$3,000 and up to \$30,000 of helping seniors get reimbursements that they are entitled to by using trained volunteers to work in the program. So I think that a \$3,000 program which for a single client can save \$10,000 of their own money is extremely worthwhile.

I do believe that at our State level there are a number of people who do feel quite strongly that the SHICAP program is quite worthwhile, but in looking at places to cut it just might be one of the places that will be cut.

If there would be funding through the Older Americans Act specifically designated for this service, then we would be able to not supplant the State funding that current exists, but we able to use that as a way of helping to start other programs that certainly need to be started.

So at this point, not having any Older Americans Act funds into the program is very difficult, and we would very much welcome the addition of the extra funding into the State units and to the area agencies.

Senator COCHRAN. Thank you very much.

Mr. Duhamel, I'm curious about Evergreen Legal Services and whether or not a grant is made available to the State of Washington that you benefit from in providing legal services; is any part of your budget made up of OAA funds?

Mr. DUHAMEL. Well, I can speak to my local office better than I can about the statewide program of Evergreen Legal Services because I'm really not that familiar with the statewide budget figures. But the Older Americans Act contributes approximately 18-20 percent of my office's budget. Without that money, that would be approximately a \$30,000 loss in my budget, and it would result in the loss of one attorney in the office, so instead of a three-attorney office we would have a two-attorney office, which would place us, in my view, in a very precarious existence considering the type of area we serve. It is so large, and we have three population centers, and it is extremely difficult to serve it with just two attorneys.

If that money were withdrawn from legal services on a statewide basis, I think we would be facing major cutbacks in a number of offices and probably office closures in certain locations.

I would think that my office would probably be targeted for closure because it is so difficult to serve with two attorneys. Now, assuming that were the case or assuming we just lost one attorney, the impact of that would be not only loss of services, of course—we still provide a certain percentage of our funding from the Legal Services Corporation and the Federal funding that comes to us to serve low-income people. A certain percentage of that is used for seniors independent of Older Americans Act money. We would still serve seniors, but at a dramatically reduced rate.

Some of the functions would just have to be eliminated. We'd have to eliminate our support of pro bono activities or training of lay advocates or outreach.

In Evergreen Legal Services—and I expect that this is true in many other legal services programs—we envision our role as being larger than just attorneys for poor people on individual cases. We do as much of that as possible but we also try to bring in other resources to help in that same mission of serving the poor and the vulnerable elderly.

So if you look at the loss of all of our senior money, which would be a one-third loss in our staff, which would be a much greater loss in senior services than just one-third, I think the effects would be extremely detrimental.

Also, I might respond to one question you asked before, if I could, which concerned attorney general enforcement of laws protecting the elderly as well as private attorneys. A couple of concerns I would have with that would be that in many cases the attorney general represents the State, and as attorney for the State in cases where clients have problems with the State or where Federal money comes through the State to our clients, they would have a conflict of interest and certainly could not represent the vulnerable elderly. Their job is to represent the State.

Also, when they do represent individual members of the public they tend to get involved with issues of public concern or public interest or public impact in a broader way, and that traditionally in our State has been defined in terms of consumer cases. They have been very active in insurance scams, they have been very active in some mobile home problems. But there are areas that only legal services has an expertise in in terms of representing low-income people.

Another problem that occurs to me is that, at least from my experience in Washington State, attorney general offices tend to focus in the locations of government. For years, there was no attorney general's office in north central Washington. They opened one recently and staff it with two attorneys to do labor and industries cases because there were quite a few filed in the countries in our region. But they just don't have the resources or the ability to reach out and do all that individual service that is our primary responsibility and our sole responsibility and focus.

In terms of private attorneys, then again, they have to look at statutes. In representing indigent people, they have to look for their award from attorneys' fee statutes, and sometimes there are award of reasonable attorneys' fees in statutes, and sometimes there are not. Attorneys are very reluctant to take cases, especially difficult litigation cases, on the basis of a speculative award at the end of a case. What often happens is an insurance company or a perpetrator of consumer fraud will come in and say basically, "We are bankrupt. You have \$1 million in claims. We have \$100,000 left. You can have it all." You don't get any attorneys' fees, or you only get 10 percent on what it would be. These are very difficult kinds of situations.

What we strive to do is reach out to those resources wherever possible, and I'd like to give a couple of examples.

In Michigan quite a few number of years ago, the ambulance companies had an association that went on TV and it says, "We're completely dissatisfied with the Medicaid reimbursement rate. We will not serve another Medicaid patient until the State increases the reimbursement rate." And nobody identified the case until clients came into our office and said, "They are charging us for things that the State should pay for, and we can't pay our bills, and they are threatening not to haul us again if we have another problem." So we went and got the tape from the TV station and got our client affidavits, went to the attorney general and said here is a Sherman Antitrust Act violation where an association of nursing home providers has banded together in restraint of trade, declaring that they won't take Medicaid patients. And the State took the case and ran, but it took our initial development to work on the case.

Another example of how it works in the private sector is in north central Washington just this year, we had a whole group of employers in one area and physicians in a hospital—they were agricultural employers in the apple industry—were all using Blue Cross of Washington as part of their employee benefit package, which is an excellent program but expensive because it pays on benefits and offers quite a few benefits. And some outfit from Oklahoma came in and said here's this great deal—you can fund your own insurance policy at two-thirds of the cost, we'll do this HMO locally. And they didn't have any money, and they didn't have any financial backup, and they were in violation of innumerable State laws. After 6 months of operation, that operation folded, and the senior vulnerable people came to us and said, "We've got all these medical bills, and they haven't been paid, and our providers are threatening not to see us unless we pay our bills."

There are wonderful remedies under ERISA, the Employee Retirement Income Security Act, and we were able to go to private attorneys in town who thought that this was a glamorous case, one that they were interested in and had some attorneys' fee potential at the end, so they took the case from us—exactly what we want.

There is no reason for us to do a case we can possibly refer to somebody else, and we work hard to do that.

Senator COCHRAN. Thank you.

Senator ADAMS. Thank you, Ty. I was going to ask you those questions, and I am glad you explained how Evergreen Legal Services works in the State. I commend you also for your program of taking young lawyers, particularly in larger law firms, and giving them the training and having them do the cases for you. I think that is a very important function and one that needs to be pressed throughout the country. I think too often our young lawyers are looking too much up the ladder and not at where their feet are and where their talents are. So I compliment you for having them do a number of these cases.

Ms. Lashway, I had a question for you. You mentioned that the AAA case management should be integrated with the nursing home discharge programs. Do you think we ought to extend this to the hospital discharge programs also?

Ms. LASHWAY. I think that the area agency case managers are in a position to know their communities and their clients probably better than anyone else in the community. And to the extent that they can expand their participation in service utilization discussions and in quality assurance and in discharge planning policies with hospitals and with nursing homes, I think that is a fine idea. It is an integrated process.

We certainly in the nursing home quality assurance program have to work with hospitals and begin to address that issue more efficiently.

Senator ADAMS. Thank you.

Ms. Anetzberger, I was particularly interested in your comment which produces an ethical and legal dilemma, which is a hands-off approach or a bill of rights, as opposed to a protective approach. And I'm not saying either is right, but I would appreciate your sub-

mitting to the committee in written form what you may feel is a way we might go about this.

I have seen it abused both ways, and I particularly enjoyed this panel because as a former United States Attorney, I can remember the problems we had of government agencies not representing their constituents. I remember the Bureau of Indian Affairs in particular and a number of others, where we would ask them, "Who are your clients?" and they would say, "The government is our client." And we would say, "No, the government is not your client. Your clients are the people that you are to be protecting." That is where—I'm not trying to have you to do this right at this moment, but you have raised this point, and I think it is something that we should approach and that we should try to do something about, either in report language or in language of the statute. We don't want people simply either put away or left in a State that they shouldn't be in, and that's what the ombudsman and many of these other services are about.

Could you do that for us?

Ms. ANETZBERGER. I would be very glad to. I think it is very difficult to balance protection and rights, and yet clearly those of us in the aging network or adult protective services have that kind of responsibility.

Senator ADAMS. I think that is true.

All statements that have been submitted by witnesses that were not given in oral form will be included as part of the record at the point where they gave their testimony.

I have a statement by Senator Pryor, and I ask unanimous consent that his statement appear in the record immediately following the statements of the other Senators, which will appear at the beginning of the record.

Without objection, that will be so ordered.

[The prepared statements of Senators Dodd and Pryor appear in the appendix.]

Senator ADAMS. I will leave the record open for additional comments for 2 weeks, and those will appear at the end of the record.

Also, there may be some additional written questions that the committee would like to submit. We'd appreciate if the witnesses would respond to those. I have only indicated one instance here publicly, but there may be other Senators who wish to submit questions.

I want to thank everyone for their attendance this morning. Particularly I want to express my appreciation to the witnesses. You have given us an excellent foundation for starting with the reauthorization of the act, and Senator Cochran and I are both grateful for your attendance.

[The appendix follows:]

Prepared Statement of Christopher J. Dodd

Mr. Chairman, I am pleased to be here this morning with my colleagues to hear these distinguished witnesses speak on one of the most important pieces of legislation ever passed by congress -- The Older Americans Act. Since its inception in 1965, the Older Americans Act has worked to ensure that all older persons - regardless of income eligibility - receive the dignity, respect, and services they are entitled to.

I am pleased that today's hearing will focus on the heart of the Older Americans Act -- maintaining the rights of older Americans. Today, in 1991, it is even more important that the Older Americans Act reinforce these rights for each older person in this country. Currently, people over 65 comprise roughly 12% of U.S. population. By the year 2020, older Americans will make-up at least 20% of the population. The fastest growing segment of this population is the "old" old, those over 65. Senator Mitchell, the Senate Majority Leader, aptly stated on Wednesday evening that long-term elder care will be the issue of the decade.

During these past twenty-five years, the 57 state agencies and 670 area agencies which comprise the aging network have done an outstanding job of delivering services to older persons. The network also provides support and advocacy assistance when older persons experience problems. The congregate and home-delivered meals programs, the job-creation programs, the in-home services, and the legal assistance and Ombudsman programs, have meant the difference for millions of people between mere existence and living life to its fullest. This is the true spirit of the Older Americans Act.

This year's reauthorization must continue this high level of commitment and quality. Programs like the Long-term Care Ombudsman program and Elder Abuse Prevention programs need to be expanded. All programs authorized through this bill must be funded. This is the only way to ensure that all older Americans - particularly those who are frail or low-income - can have the access they need to these programs. The older Americans of today as well as the older Americans of the future deserve nothing less.

Senator Adams, as the new Chairman of the Subcommittee on Aging, I wish you well. I am very pleased to be an original co-sponsor of S.243, The Older Americans Reauthorization Act. Mr. Chairman, I look forward to working with you closely on these issues.

Prepared Statement of David Pryor

I want to commend Senator Adams for convening this morning's hearing on the rights of vulnerable elders to kick off the 1991 Older Americans Act reauthorization process.

I look forward to reviewing the testimony of this morning's most impressive array of witnesses. Their broad experience and commitment to the elderly will help us to explore ways to strengthen advocacy efforts on behalf of older Americans.

As you know, in preparing for this year's reauthorization, the Senate Special Committee on Aging convened a series of workshops to identify changes that may be necessary or desirable during the reauthorization process. The third session in the workshop series examined barriers to effective advocacy on behalf of vulnerable senior citizens. Although this forum focused on the experience of two services authorized under the OAA which have a unique client advocacy mandate, the long-term care ombudsman program and legal assistance, I believe that advocacy extends well beyond these two services. All members of

the Aging Network, from the Administration on Aging to service providers, and all OAA services, from employment counseling to home-delivered meals, should serve, first and foremost, as advocates for older persons.

For the past 25 years, the OAA has been a tremendous success in maintaining the independence and dignity of our nation's senior population. The long-term care ombudsman program, established in 1978, has expanded dramatically across the country, providing vital advocacy services to vulnerable residents of nursing homes and board and care facilities. Despite the substantial achievements of the program, resources have restricted the ability of the program to assure adequate advocacy services to all residents of these facilities who are at risk.

In order to work towards improving the ability of the ombudsman program to meet the demands of an increasing elderly population, my proposal for the reauthorization includes a provision to establish a National program for recruiting and training volunteer ombudsmen. Volunteers have been particularly useful in expanding the capability of the ombudsman program to reach vulnerable elderly persons.

The OAA also recognizes the critical importance of legal assistance services. Title III of the Act identifies three priority areas, including access, in home, and legal services. Organizations and private attorneys continue to face substantial barriers to providing effective legal advocacy. Accordingly, my proposal directs the Administration on Aging to develop standards for area agencies on aging to follow in choosing and evaluating legal services providers. In addition, my proposal authorizes additional funding for states to provide support and assistance to older Americans who need help in areas such as living wills, durable powers of attorney, and other life planning areas.

This year's reauthorization provides us all with a unique opportunity to advocate on behalf of our nation's vulnerable elderly population. It is our job to ensure that these individuals maintain their dignity.

I would like to thank the distinguished Chairman for allowing me to include my remarks in the record of this most important hearing. I look forward to working with him, Senator Cochran, and all other interested members as the comprehensive OAA reauthorization legislation is developed within the Subcommittee.

Prepared Statement of Arthur S. Flemming

I. Introduction

- A. I am delighted, Senator Adams, that you and your colleagues on the Subcommittee on Aging are beginning your hearings on the reauthorization of the Older Americans Act by focusing on the role and effectiveness of the Older Americans Act in protecting the rights of the vulnerable elderly.
- B. I was appointed U. S. Commissioner on Aging in 1973.
 1. The 1973 amendments to the Older Americans Act provided the foundation for the development of a network of state and area agencies on aging.
 2. We assumed--from the outset--that advocacy in behalf of older persons, with emphasis on vulnerable older persons, was one of our major responsibilities.
 3. I am delighted that the Act now includes specific responsibilities for advocacy for the U. S. Commissioner on Aging as the head of the Administration on Aging, the administrators of state agencies on aging, and the administrators of area agencies on aging.
 - a. The law states unequivocally that "it shall be the duty and function of the Administration (on Aging) to serve as the effective and visible advocate for the elderly within the Department of Health and Human Services and with other departments, agencies and instrumentalities of the Federal government by maintaining active review and commenting responsibilities over all Federal policies affecting the elderly."

- b. The law also specifies that state agencies on aging shall "serve as an effective and visible advocate for the elderly by reviewing and commenting on all state plans, budgets and policies which affect the elderly and providing technical assistance to any agency, organization, association or individual representing the needs of the elderly.
 - c. And finally the law provides that the area agency on aging "would serve as the advocate and focal point for the elderly within the community by monitoring, evaluating, and commenting upon all policies, programs, hearings, levies, and community actions which will affect the elderly."
 - 4. I like the wording in the charge to the Administration on Aging, namely, "it shall be the duty and function of the Administration on Aging to serve as the effective and visible advocate for the elderly."
 - a. The state agencies are charged to "serve as an effective and visible advocate for the elderly."
 - b. The area agencies are told to serve as "the advocate and focal point for the elderly."
- C. The Act makes it clear that in discharging all responsibilities under the Act--including the responsibility of advocacy--preferential consideration should be given to those "with the greatest economic and social needs" and to all "vulnerable elderly."
 - 1. The Act says that "the term 'greatest economic need' means the need resulting from an income level at or below the poverty levels as established by the Office of Management and Budget."
 - 2. The Act also says that "the term 'greatest social need' means the need caused by non-economic factors which include physical and mental disabilities, language barriers, and cultural, social or geographical isolation including that caused by racial or ethnic status which restricts an

individual's ability to perform normal daily tasks or which threatens such individual's capacity to live independently."

3. In brief, the Act says to those involved in its administration: Open up the doors of opportunity for the poor, the isolated, and the victims of discrimination.

D. Finally, the Act has provided those charged with the responsibility of advocacy with access to two very important processes--legal service and ombudsman--in their efforts to make sure that older persons have access to and receive the quality of services to which they are entitled by law.

II. Body

- A. It is my belief that an excellent start has been made in building a legal foundation on which an effective advocacy program designed to protect the rights of older persons--especially vulnerable older persons--can be developed.
 1. I am sure that the hearings of this Subcommittee will establish the fact that some real progress has been made in establishing such a program.
 2. I am likewise sure that the hearings will also identify some missed opportunities.
- B. I note, for example, that in at least two parts of the Act specific responsibilities are assigned in connection with Title XVI of the Social Security Act or the Supplementary Security Income Program for the Aged, Blind and Disabled.
 1. I am chairing a group of persons from outside of government that has been brought together by Social Security Commissioner King to participate in what she has designated as ^{the} SSI Modernization Project.
 2. As a result of our deliberations and of the opportunity I have had to visit local Social Security offices within the Social Security regions I have concluded that the Administration on Aging--as well as other public and public groups have missed many opportunities to serve as effective advocates for the poorest of the poor among the elderly, the blind and the disabled.

- C. Then, to take one additional example, I also believe that the Administration on Aging as well as other public and private groups have failed as advocates in protecting the rights of older persons under the Age Discrimination Act.
- D. Both of my illustrations relate to laws that are administered by units in the Department of Health and Human Services that are not administered by the Administration on Aging.
1. The Administration must of course recognize its advocacy responsibilities in connection with the programs for which it has responsibility--its responsibility, for example, to insure that preferential consideration in the delivery of services is given to the poor and other victims of discrimination.
 2. From the beginning, however, the Congress has emphasized the Administration on Aging's responsibilities as a "watch-dog" in connection with many other programs administered by other agencies which play a major role in the lives of older persons.
 3. For example, in spelling out the advocacy responsibilities of the U. S. Commissioner on Aging, the ^{of the Administration} Act identifies the following programs related to the purposes of the Act:
 - (1) the Job Training Partnership Act,
 - (2) title II of the Domestic Volunteer Service Act of 1973,
 - (3) titles XVI, XVIII, XIX, and XX of the Social Security Act,
 - (4) sections 231 and 232 of the National Housing Act,
 - (5) the United States Housing Act of 1937,
 - (6) section 202 of the Housing Act of 1959,
 - (7) title I of the Housing and Community Development Act of 1974,
 - (8) title I of the Higher Education Act of 1965 and the Adult Education Act

E. I believe that "Advocacy" should be at the top or close to the top of the Administration on Aging's "action program."

1. I do not believe it is there.
2. I believe that the Congress and the field of aging share responsibility with the Executive Branch for the present situation.

F. I believe that the Congress could play an important role in elevating "Advocacy" in the Administration on Aging by taking the following steps:

1. Bring the advocacy assignments and the processes supporting those assignments, ^{the Ombudsman + legal services} that are now in the Act together in a new title.
2. Grant the U. S. Commissioner on Aging, as a part of the advocacy functions assigned to the office, the authority to hold hearings and, as a part of the hearings to subpoena witnesses and place them under oath.

In drafting this authorization I suggest that consideration be given to the manner in which the U.S. Commission on Civil Rights was authorized to proceed by the Congress.

I also suggest that consideration be given to authorizing the Commissioner to delegate authority to hold specific hearings to an official reporting to the Commissioner and to state and area directors of aging.

3. Amend the language in the existing Act relative to the ombudsman process so as to make it possible for this process at the federal, state and area levels to be of maximum assistance to the U. S. Commissioner on Aging in the discharge of advocacy responsibilities, including the holding of hearings, and to state and area agencies on aging in their discharge of advocacy responsibilities.
4. Evaluate the resources now available for the advocacy process to determine (a) whether they are adequate to carry out the present intent of Congress, and (b) what additional

resources would be needed in order to discharge any new responsibilities in this area.

III. Conclusion

- A. A strong advocacy program is a "must" if the rhetoric of the "Declaration of Objectives for Older Americans" as set forth in Title I of the Older Americans Act and the rhetoric of the titles designed to carry out the declaration is to be translated into reality for a maximum number of the older persons of our nation.
- B. I hope that this committee will start us down the road that will bring together the pieces of our present advocacy program into a new section, and will then strengthen the various components of the program.
- C. Above all I hope that the members of the committee will do everything within their power to see to it that adequate funding is provided.
 - 1. I am deeply concerned about the attacks that are made on public servants for their failure to discharge adequately responsibilities of this nature when what is missing is not lack of will but lack of resources.
 - 2. I am well aware of the difficulties that are involved in dealing with this issue but I believe that we must confront them together and find some way to overcome them.
- D. Thank you for this opportunity; I look forward to talking with you further about this and other issues involving the Older Americans Act.

Prepared Statement of Patricia A. Riley

Mr. Chairman, Members of the Subcommittee on Aging:

My name is Trish Riley and I currently serve as Executive Director of the National Academy for State Health Policy, a non-profit organization dedicated to advancing innovative health policy and programs within the states. However, I speak today as an individual and not on behalf of any organization. While I have not held a position within the aging network since 1985 when I was director of a state unit on aging, it is a particular pleasure to have this opportunity to reflect upon the Older Americans Act and its role in protecting the rights of vulnerable elderly.

Quite frankly, my deepest appreciation for the OAA came after I left the network and became director of an agency responsible for Medicaid, health planning and licensing and certification. The Act's singular focus on and direction from older persons themselves and its responsibility to assure that elderly receive the full rights and privileges of society comprise its strengths. Without such a clear client focus, an agency like Medicaid can easily lose its perspective on the consumer amidst the competing demands to increase health care access for all client groups, retain sufficient numbers and types of providers, expand the types of services provided, restrain costs and provide for timely and effective claims processing. Entangled in the complex machinations of such a program, other agencies view the intent of the Older Americans Act to protect an elderly person's rights, as almost a luxury. Yet, asking a society to recognize what a vulnerable older person wants and is capable of achieving and assuring that person choice and self determination, no matter how vulnerable, ought to be the first test of a government program, not a luxury.

It is the aging network alone that can and must stand up for the rights of the elderly - even when their choices conflict with professional norms of behavior and institutional expectations. While a Medicaid program may deny service to a vulnerable elderly person in what is perceived as an "unsafe environment", the network must fight for that service, must always demand the rights of the individual over the needs of the institution and represent those consumers when compromise is essential. But, such a role is contrary to bureaucracies which, by their nature, set norms, limits, measures, standards. Still, it is the network's

responsibility to change systems and programs to reflect the needs of the elderly and that responsibility is particularly important for the vulnerable who may not be fully able to represent themselves in complex bureaucratic arenas.

But, advocacy can become tokenism and paternalism particularly if we assume to speak for elders without their voice and, like planning, advocacy is difficult to measure. In large bureaucratic and political organizations like state governments, an agency's power and authority is largely measured by the size of its budget and the scope of its authority. One need only look at the attention given to state Medicaid agencies (or at a national level, the visibility of HCFA versus AoA) to understand this reality. Thus, too often, the aging network is understandably drawn to the role of program administrator as a means to have more clout in system change and to be viewed as a peer among larger agencies like Medicaid, housing authorities, income maintenance units and others. Surely the network's leadership in developing home care systems and administering Medicaid Home and Community Based Waivers bears witness to the efficacy of such an approach. When you run a program, making change is often quicker than gaining another agency's attention and convincing that agency to change. In home care, many state units on aging have successfully built innovative programs and deserve praise. But, the difference between building a system and becoming that system warrants attention as we examine how best to protect the rights of vulnerable elderly.

Of course, each state is different and what works in one will not work in another, but I worry about the trend to become like other agencies and actually administer programs like home care or Adult Protective Services. The job of running a program is different from advocacy - if we are the system, who is our master? If we are the system, who will provide oversight and advocacy to assure that systems reflect and represent older persons?

Conversely, if we are not the system - agencies operating like Medicaid with big program and budget responsibilities - how will we make change happen? How can the OAA help state units retain their essential advocacy functions, particularly amidst the current state budget climate in which all but essential services are being eliminated?

The OAA can stay the course by insisting that states retain advocacy programs and by providing sufficient funds to state agencies, with sufficient discretion about their use, to support advocacy.

The first tool of effective advocacy is sound information and good ideas which represent the constituency. Thus, state units need sufficient resources to collect and share data and retain close communication with the elderly. Citizen advisory committees, public education, special studies and research all should be funded activities of state units on aging. In Maine, we were able to achieve significant gains, for example, in elderly housing and create one of the first state funded congregate housing programs by conducting special studies and needs analysis, convening forums and staffing collaborative task forces and paying for expert consultations. The OAA provided the flexibility for the network to fund such initiatives which were not allowable under more prescriptive programs. Such flexibility is a hallmark of the Act and crucial to protecting rights. I would also suggest that each state unit on aging, working with its area agencies and citizen advisors, regularly publish a report card on the state's progress in advancing the rights of the vulnerable elderly. We cannot protect the rights of the vulnerable elderly until we understand as a society what those rights are and when violations occur. What such a "report card" should include requires more consideration, but some measures might be:

- Number of eligible elderly currently receiving SSI, Medicaid, foodstamps, housing assistance;
- Percent of elderly in poverty and near poverty and who live in substandard housing;
- Current Medicaid coverage for the elderly;
- Number of elderly receiving mental health services;
- Percent of institutionalized elderly and nursing home beds per 1,000 elderly;
- Number of foster care, housing and alternative living arrangements available to elderly;
- Number of elderly receiving Adult Protective Services; and,
- Number of elderly receiving home care.

Some of this data is difficult to collect. Much of it is already collected, but not well or publicly presented and understood. A Federal mandate to collect and present it simply and to the public might threaten some state leaders. And while this data may go far to counteract the prevailing myth of elders who selfishly seek service for themselves at the expense of others, it should also include measures of successful aging. These regular reports would provide a public education tool, a comparison among states and a baseline to measure progress and failure. Such a tool is clearly limited in its utility and can be over-simplified and reduced to a measure of numbers at the expense of less quantifiable, but equally critical measures of success. But, it is a first and important step. Once we document problems, our more difficult job is to assure that existing systems meet the needs of elderly in ways which assure their maximum independence and self control.

As I look to the types of issues the network needs to address to assure the rights of vulnerable elderly, it becomes clear that advocacy requires highly skilled staff at the Federal, state and local levels and that capacity ought to be carefully reviewed and encouraged. As states have engaged in a variety of advocacy issues, they have had the need for expert technical assistance regarding Medicaid law, SSI law and regulation and other areas outside the scope of traditional AoA responsibilities. Increasingly, the National Association of State Units on Aging has provided that expert help and such capacity building needs to be still further encouraged.

The number and type of issues the network should address are large indeed and range from economic security, housing, transportation, quality of care, "right to die" provisions and protections, consumer credit, insurance, tax policy - all of which change rapidly and require competent staff to respond. But, let me discuss just a few issues in health policy in which I think the OAA has a particularly important role to play.

Currently, 27 states are engaged in efforts to cut substantially their current services budget. In a number of them, Medicaid Medically Needy programs are on the chopping block - a program which particularly assists the elderly, who, but for high medical costs, are not otherwise eligible for Medicaid. In others, innovative home care programs are being cut or rural hospitals closed. While a compelling case can be made to close nearly empty rural hospitals, rural areas tend to be disproportionately comprised of elderly and when hospitals

close, doctors leave, emergency systems close, nursing homes lose essential support, and it is the elderly who are hurt. The network must be a watchdog on that system and must propose reasonable solutions that meet budget concerns without compromising the vulnerable elderly. The network can also provide important outreach functions to assure that elderly receive the Medicaid benefits for which they are entitled. Recent Medicaid reforms have provided for presumptive eligibility for pregnant women and required that eligibility workers be placed outside (outstationing) Medicaid or welfare offices to encourage greater outreach to pregnant women and children. These same provisions might be considered to encourage the elderly to participate in Medicaid. Presumptive eligibility allows a state to determine a person eligible for Medicaid immediately - and not wait up to 45 days for that determination - if certain criteria are met and the person appears likely to be eligible. If elders did not need to wait for eligibility, delays in hospital discharge could be avoided and service could begin more quickly.

The aging network can also play an important role in nursing home reform. In this difficult economic environment, nursing homes may also close or change hands. The Ombudsman Program, free from constraints of regulatory agencies or providers, can represent consumers not only on a case by case basis, but in system change by commenting on proposed rules and intervening in certificate of need determinations. The process of securing state approvals to build or buy a nursing home is frequently extraordinarily complex and largely financial. But, certainly as important to the decision of whether or not a nursing home can be financially viable is the quality of its care. Residents have little voice in determining which nursing homes are authorized and licensed, but their Ombudsman, if research is carefully and skillfully done, can and should investigate a nursing home applicant, determine its track record if it has operated in other states and intervene in public hearings to hold it to a test of quality. That kind of advocacy served Maine nursing home residents well in more than one occasion in difficult certificate of need decisions.

Similarly, the network can and should examine how care to elderly within hospitals can be improved. However, that requires an understanding of the complex field of hospital financing and licensure. Studies have clearly documented that too many elderly are hospitalized simply due to avoidable drug interaction or delayed medical care. Once there,

the elderly are apt to become sicker and more impaired and are then placed in a nursing home which could have been avoided. Medicaid agencies - who pay a large part of the hospital bill - have little motivation to improve elderly acute care because that service is largely funded by Medicare and any savings generated would accrue to the Federal government, not the state. But, state aging offices, with proper skill and good ideas, could propose meaningful reform.

Currently, most state agencies on aging address some or all of these issues to some degree. But, their capacity to truly assure the rights of vulnerable elderly is too often limited by insufficient resources and inadequate flexibility in how they can be used, unclear goals and expectations regarding their advocacy mission and insufficient technical support and assistance.

The proposal to establish a separate authorization within the Act to give states the ability to enhance their unique role as advocate of elder rights deserves support. As state budgets are cut, the network must be the guardian of the good for all elderly, particularly those most vulnerable. To do so requires the consistent capacity to analyze a variety of public and private programs and policies and to document problems and propose solutions and that requires tools and unshakable Federal support. I urge you in this reauthorization to further your support for this advocacy role in any way possible.

I appreciate this opportunity to comment. Thank you.

Prepared Statement of Billie J. Marshall

I INTRODUCTION

The State Unit on Aging for Mississippi is located within the reorganized Mississippi Department of Human Services and is known as the Division of Aging and Adult Services. Created by the Executive Branch Reorganization Act of 1989, the Mississippi Department of Human Services is one of the largest agencies in state government with more than 5,000 employees and an annual operating budget in excess of \$380,000,000.

The Department administers 60 separate human service programs through seven (7) programmatic divisions. It is estimated that over a million Mississippians are served annually by the programs provided through the Department.

Operating within both federal and state guidelines the mission statement for the Department states that:

The Mississippi Department of Human Services (MDHS) is a primary link between families and individuals with specific needs vital to their survival and the services available to meet those needs.

The Mission of MDHS is to deliver, within established guidelines, a broad range of services to a diverse population in a professional, timely, accurate and compassionate manner. MDHS will further its mission by assisting those in need to overcome adversity, dependency and lack of self-esteem and gain self-confidence and self-sufficiency.

The Divisions of the Department include:

- ° Economic Assistance
- ° Rehabilitation Services
- ° Community Services
- ° Family and Children's Services
- ° Child Support Enforcement
- ° Vocational Rehabilitation for the Blind
- ° Aging and Adult Services

In addition the Department also houses:

- ° Office of Policy and Special Initiatives
- ° Office for Children and Youth
- ° Social Services Block Grant Program
- ° Mississippi Industries for the Blind

The Department is under the leadership of its Executive Director, Mrs. Beatrice J. Branch and a five-member Board that is appointed by the Governor.

Aging and Adult Services, which is also identified as the Council on Aging, administers nearly \$15 million each year in federal funds to provide programs and services for Mississippi's 60+ citizens. The Division receives no state funds other than that which is required as match. The Aging and Adult Services

Division does not provide direct client services, but instead makes grants to the ten Mississippi Planning and Development Districts which in turn fund ten Area Agencies on Aging.

In addition to oversight responsibilities, the Division provides training and educational activities for aging network staff; health promotion programs in conjunction with the Mississippi State Medical Association; research and analysis on issues affecting the elderly; and collaboration opportunities for other agencies/organizations.

All of the specialized services available to Mississippi's senior citizens through the Division emphasize our commitment to helping older persons remain in their own homes, as independently as possible, for as long as practical. Our first priority is always to maintain vital services to the frail and homebound.

II. PROTECTIVE SERVICES FOR OLDER MISSISSIPPIANS

Issues affecting and impacting on the rights of older Mississippians are addressed by four different agencies or organizations:

1. Attorney General's Office, Medicaid Fraud Control Unit;
2. Mississippi State Health Department, Licensure and Certification Division;
3. Division of Family and Children's Services, Office of Social Services, Adult Protection Unit; and
4. Division of Aging and Adult Services, Long Term Care Ombudsman Program.

The Medicaid Fraud unit is authorized by the Mississippi Medicaid Fraud Control Act, (Miss Code 1972 Sections 43-13-201 et seq.). Housed in the Attorney General's office, it is charged with investigating and prosecuting violations of Mississippi's Medicaid Law.

The Licensure and Certification Division of the Mississippi State Health Department is authorized by various provisions of state and federal law to license and supervise health care

providers including hospitals, nursing homes, personal care homes and home health service providers. Its functions include surveys of nursing facilities under federal health care law and investigation of allegations of violation of regulatory standards.

The Division of Family and Children's Services is authorized to carry out the Vulnerable Adults Act, Mississippi's basic Adult Protective Services law. Those responsibilities include investigation of reports of suspected abuse, neglect or exploitation and provision of protective services for vulnerable adults in a non-institutional setting.

The Long Term Care Ombudsman Program is authorized under section 43-7-65, Mississippi Code. Recent amendments now provide access to facilities and resident records.

Despite the legitimacy of the Ombudsman program as a result of state legislation, it still is viewed with some opposition from the industry and agencies within the aging network itself. In an effort to address these concerns the Ombudsman program emphasizes again and again that it is neither regulatory nor punitive. It attempts to become a legitimate member of the nursing and personal care home team, serving as a liaison between residents, families, facility staffs and the community. The primary goal of the program is to work in a non-intimidating and constructive manner to protect the interests of long term care residents and to be an effective advocate for the improvement of life for our state's aged and infirm.

A shining example of a coordinated protective services system in our state, which utilizes Older American Act funds, is the local Ombudsman program in the Southern Mississippi Area Agency on Aging. Mrs. Jane Kennedy, who is the AAA Director, wisely I believe, contracted the Ombudsman program to the South

Mississippi Legal Services program. The Ombudsman Program Coordinator is a paralegal in that office. The collaboration and coordination activities, the "marriage" between the two programs, ensures the protection of older citizens in that Planning and Service Area regardless of their residence in an institution or non-institutional setting.

In an effort to better protect the rights of Mississippi's elderly and to address the issues surrounding these rights, the Division of Aging and Adult Services has recently been charged with the responsibility of developing and implementing an interagency system of Adult Protective Services within the department. Because our department has the responsibility for implementing both the Vulnerable Adults Act and the Ombudsman program this charge recognizes the need for coordination as we address the rights and needs of the elderly regardless of their residence.

This system, which we have tentatively identified as Comprehensive Adult Protective Services System (CAPS), will combine a multitude of services and draw upon every resource available to the vulnerable, abused and exploited adult or elderly person in every community within the state. This system will incorporate a unique mixture of legal, medical and social services that will provide a broad array of resources for agencies with which CAPS will collaborate.

This concept will be a comprehensive client-centered multi-disciplinary system, which will emphasize the prevention as well as the investigatory aspect of the protection of the elderly. It will, when appropriate, involve local services and programs of each AAA.

Although we are in the preliminary planning stages of the CAPS system, my point for sharing this information is to emphasize that the Older Americans Act with its emphasis on advocacy and protection and the Administration on Aging's thrust regarding elder abuse prevention, is the catalyst for our thinking and development.

III. A PERSPECTIVE ON HOW THE OLDER AMERICANS ACT CAN MORE EFFECTIVELY PROMOTE THE RIGHTS AND INDEPENDENCE OF VULNERABLE OLDER AMERICANS

The Older Americans Act provides the guidance and "game plan" to ensure that systems are in place to promote independence and protect the rights of older Americans. It is essential that the Act be constantly and consistently refined and enhanced to ensure its appropriateness and impact.

We would all agree, I'm sure, that there are basic rights that the elderly have that go beyond those that are outlined in our Constitution. These rights include:

- ° The right to an adequate income which will provide for life's basic necessities;
- ° The right of access to information for making informed choices and decisions;
- ° The right to have opportunities to be involved in meaningful roles and activities;
- ° The right to remain productive members of the community;
- ° The right to expect and receive adequate health care;
- ° The right to be free from restraints on life and property; and
- ° The right not to have one's liberty compromised.

Because of the increasing issues and concerns regarding abuse, neglect and exploitation of the elderly, within and outside of institutions, it is especially crucial that a systematic strategy for addressing these issues and concerns be a part of the Older Americans Act.

As an older person attempts to access needed services, the problem, or potential for a problem, comes when he or she has to rely on another person or institution.

If one has to rely on an institutional system such as Medicare and/or Medicaid for basic health care, the system itself can become abusive as it attempts to ration limited funds among the beneficiary population. Rigid policies and practices

frustrate the beneficiaries because they can be too complicated to easily understand and because they can be too rigid and inflexible in unique situations. Whether objectively justifiable or not, those frustrated beneficiaries often feel that the system simply is not just.

If one has to rely on an institution such as a nursing home or even in-home providers for assistance in merely surviving, that institution can become abusive by virtue of its need to survive financially. The payment is often insufficient to purchase the kind of care that would be more responsive. The institutional setting itself - even when there is no intention to abuse or neglect - can cause grief and anxiety among those it is designed to benefit.

If one has to rely on family members, friends, or others in the community for assistance with finances or life decisions, there are opportunities for abuse. Some of that abuse may be intentional, but much of it comes from the frustration that the "assistance giver" feels in his or her inability to cope with the responsibilities that go with giving assistance.

All efforts to deal with the rights of the elderly should look closely at the very basis of how well we care for the elderly in our society. If we build systems that abuse, then abuse can be expected. If we can build systems that nurture and provide, then that kind of result is more likely. An example that comes to mind is a "claims examiner" looking at a claim for benefits under Medicare/Medicaid or even private insurance. As the system presently operates, it appears that he looks for anything in the claim that would cause it to be denied and if he can't find anything, then it is paid. In other "benefit" programs, there is the same emphasis; the benefit is granted if no disqualifying conditions are found. What the aging network has to be about is finding ways to do the opposite - we need to look for ways to get an older person what he or she needs to live with dignity and independence. When that kind of care system is

established, it will not be necessary to attack the system to force it to do what it is supposed to do.

Given these life realities, The Council on Aging would suggest that the major emphasis of the 1991 amendments should continue to emphasize and strengthen the development and implementation of comprehensive community-based long term care systems which include elder rights and advocacy. The specific issues of concern in this regard are that:

- A new title be established which encompasses advocacy, rights and entitlement, protective services, counseling, legal assistance and ombudsman activities for in-home as well as institutional care.
- The amendments should contain stronger statutory provisions to target the "old-old", low income minorities and rural citizens.
- The funding formula to states should reflect individual state demographics just as states must use in their intrastate funding formulae.
- Much more focus should be placed on collaborative efforts with other relevant federal level agencies in serving older citizens.
- Stronger language should be added to encourage the development of private sector/aging program relationships.
- Programs should place more emphasis on support services for family members and caregivers who provide voluntary assistance to frail, vulnerable and homebound older persons.
- More attention should be given to information and referral, outreach, public information and public education.

In order to be effective within the framework of these recommendations to promote the rights and independence of vulnerable older Americans in the 1990's, the Older Americans Act

needs to be adequately funded, including new funding for the suggested new title for elder rights and advocacy.

It is essential that the Older Americans Act provide proactive opportunities to promote and network with a cadre of agencies and organizations concerned with ensuring the rights of older Americans. This would include actual program development and implementation as well as the responsibility to monitor laws, regulations and policies impacting, on a larger scale, those issues of rights of the elderly.

Programs funded under the Older Americans Act provide a unique opportunity to develop public/private partnerships with providers responsible for ensuring that the rights of the elderly are not compromised.

Older American Act programs provide community services which allow older persons to remain independent and in their own homes; further, they can delay or prevent institutionalization as well as help smooth the transition between an institution and the older person's home.

The Older Americans Act must not only be the framework for the development of programs which address the changing needs of the elderly, but it must also serve as the catalyst which continuously challenges us as we view the changing demographics and needs. Reauthorization provides an opportunity to strengthen and improve the ability of the aging network to develop and implement a broad array of services for America's aging population. The focus has moved from the isolated arena of the delivery of limited but specific services to the broader perspective which goes beyond service delivery to program planning, development, and coordination, to the mobilization of a number of resources which address and reflect the changing needs of the elderly today.

The Older Americans Act has become scattered. It should be more focused. This focus should be on protecting and enhancing elder rights, their dignity, autonomy, and financial security, in particular, those that are most socially and economically disadvantaged.

Prepared Statement of Michelle P. Holzer

Mr. Chairman, Committee members, good morning. I appreciate this opportunity to discuss with you the inclusion of protection of consumer rights as related to the reauthorization of the Older Americans Act. As Coordinator of the Maryland State Office on Aging's Senior Health Insurance Counseling and Advocacy Program (SHICAP), I see the inclusion of health insurance claims assistance, counseling and advocacy programs as a mandated service in the Older Americans Act, with sufficient resources to carry out the program, as an essential element to help secure the consumer rights, with regard to Medicare and other health insurance issues, of seniors in this country. 1

All too often, the seniors in our country do not fully understand the benefits and limitations of the Medicare program, nor their supplemental health insurance or "Medigap" policies. They are subject to pressures placed on them by insurance agents who prey on their fears and often convince them to purchase more insurance than they need or to replace perfectly adequate existing policies. They succumb to the many unscrupulous tactics and practices fostered by some insurance agents and companies. Many seniors are unable or unwilling to submit or follow-up on their insurance claims, resulting in millions of dollars of uncollected benefits in the hands of insurance companies, and not to our seniors, many of whom are already living on a tight, fixed income. In some cases it is a choice between proper nutrition, their prescription drugs, and paying the doctor. Often times, the doctor

gets paid first. For many seniors, it is just too difficult to handle the Medicare and Medigap maze they must deal with in order to collect their benefits. They would rather just pay the bill than to get involved with burdensome paperwork and bureaucracy. This is especially true if the claim is disputed and gets to the reconsideration or appeals stage, the senior would often just pay the bill than to become entangled with a hearing or court case. Seniors are extremely fearful when a bill goes into collection, and they start to get threatening letters from collection agencies; they have always paid their bills on time and are not accustomed to harassment from bill collectors. This is indeed a pity, especially when the senior has been paying on an insurance policy that is slow or is balking at paying a legitimate bill.

Our clients often need to be empowered to exercise their consumer rights. Our seniors have the right to question their doctors about not only their condition and treatment plan, but also the financial cost to them, particularly if alternative treatment modalities are available, perhaps at a lower cost. They have the right to request their doctors to accept assignment, particularly if a financial hardship will result. Many physicians will accept assignment if approached, but their senior patients are hesitant to ask for what they feel is charity. Seniors have the right and responsibility to fully understand their Medicare and Medigap coverage, and to get clear answers to their questions. They have the right to get their bills submitted to Medicare on a timely basis, and to get prompt payment by Medicare and their supplemental insurance carriers. All too often a senior is requested to pay a bill "up front" when a doctor does not accept Medicare assignment, and then because the physician has a year to submit that bill to Medicare, the senior may have to wait quite a while for reimbursement. Seniors have the right to get speedy and courteous service from Medicare and Medigap representatives regarding their

claims and disputes about claims. They have the right to make insurance purchase decisions without harassment and pressure, and with full disclosure regarding benefits provided, service limitations and exclusions, right to renew, right to cancel, "free look" provisions, options available, and rate structures. They have the right to be able to read through their insurance documents and contracts in large enough type, prior to making a decision. They have the right to fully draw upon their benefits without arbitrary and capricious restrictions. Seniors also have the right to fully exercise all protections available to them through current State and Federal laws and regulations, and to access those agencies and organizations involved in regulating and licensing providers of medical care services and/or the insurance industry.

I'd like to outline how Maryland has addressed this issue most successfully. I would also like to call your attention to the additional information I submitted to this Subcommittee. The Maryland Office on Aging's Senior Health Insurance Counseling and Advocacy Program has four main program elements:

- claims handling activities related to Medicare and Medigap claims;
- one-on-one counseling services regarding Medicare, Medigap, and long term care insurance issues, including assistance to seniors in understanding different policies so they can make more knowledgeable decisions in selecting appropriate insurance products;
- informal advocacy, intervention and representation in the event of negotiations with medical care providers, and/or legal intervention and

representation in reconsiderations or actual hearings with respect to Medicare or Medigap carriers; and

- public education and dissemination of printed information regarding Medicare, Medigap, long term care insurance and consumer protection issues.

Maryland's SHICAP program is presently operating in 14 of 24 jurisdictions, funded by State grants to 11 Area Agencies on Aging (one Area Agency serves a multi-county region). In Fiscal Year 1991 (July 1, 1990 through June 30, 1991), the grant budget is just over \$166,000. We primarily rely on training volunteers to provide the services, supported and monitored by staff coordinators. Although still a pilot program, not yet available statewide, Maryland's Senior Health Insurance Counseling and Advocacy Program is one of eleven programs of this type recognized nationwide as a leader in this effort. In Fiscal Year 1990, approximately 3,400 clients were served, receiving assistance in Medicare, supplemental health insurance and long term care insurance claims matters, counseling, and/or legal advocacy. In addition, public education presentations reached over 8,100 individuals, and over 4,200 individuals were assisted over the telephone. There are about 150 volunteers presently serving as Senior Health Insurance Counseling and Advocacy Program counselors. SHICAP is a program where an individual is assured that they will receive objective assistance free from any conflict of interest. With hospitals, nursing home corporations, insurance companies, health maintenance organizations, and many other entities aggressively marketing health plans and insurance, seniors need programs and agencies where they can turn for objective assistance. State Units on Aging sponsored health insurance claims assistance and counseling programs do not duplicate other State and local services, but complement them by acting as the eyes and ears for State Insurance Divisions, Attorney General's Offices, and consumer protection agencies which do not operate through an established network system reaching the senior

population. We are able to reach out to large groups of seniors in a non-threatening environment, utilizing peer counseling and assistance, including home visitation as needed to particularly frail and infirm elderly clients.

Mr. Chairman, Committee members, I urge you to consider the inclusion of health insurance claims, counseling and advocacy programs, with sufficient resources to carry out the program, as a mandated service in your deliberations with respect to the reauthorization of the Older Americans Act. Protecting the consumer rights of our vulnerable senior citizens should be an essential part of services provided through the established aging network. Thank you for the opportunity to present to you today.

CASE STUDIES

MARYLAND OFFICE ON AGING SENIOR HEALTH INSURANCE COUNSELING AND ADVOCACY PROGRAM

* Mr. J had been paying his wife's nursing home bills at the rate of \$148 per day, which was to be reimbursed through an insurance policy. Due to billing problems, Mr. J was unable to obtain proper documentation from Medicare and from the nursing home, necessary to submit to his insurance company. After intervention from the local Senior Health Insurance Counseling and Advocacy Program (SHICAP) volunteer, with assistance from the local Ombudsman, the volunteer was able to submit the necessary paperwork and get \$30,542 in back insurance benefits.

* A client called the local SHICAP project because she was running short of funds to pay her high medical bills; she was even thinking of putting her house up for sale to pay them. The SHICAP volunteer met with her and found out that she was paying all her medical bills in cash and then forgetting to submit her supplemental insurance claims. The SHICAP volunteer was able to get \$1,400 reimbursed to her.

* After working with a senior client, the SHICAP volunteer estimated a total savings of \$2,160 in recouped claims and elimination of double insurance coverage. In addition, the volunteer was able to get his paraplegic client a wheelchair, paid through the Medicare Program, which the client had been trying to obtain for over a year.

* Mr. H had been hospitalized in early 1988 at a local private psychiatric hospital on two separate occasions. He did not have Medicare A or B. He was covered under the Federal Employees Health Benefits Plan (low option Blue Cross/Blue Shield) and his wife's State of Maryland Blue Cross/Blue Shield/Major Medical Plan. Mr. H's accountant had worked through all of his bills, but by October 1990, there was still a \$3,085 unpaid bill due to the hospital.

Because the accountant was stonewalled in his efforts to determine which insurance, if any, was responsible for this remainder, he turned to the State SHICAP Coordinator (there was no local SHICAP project in his county). After much investigation and the waiving of numerous time deadlines, we were able to resolve this bill in January 1991 (three years after the hospitalization), resulting in full payment of all bills concerned. In addition, Mr. H's insurance coverage has been modified to better serve his needs.

* Mrs. L's durable medical equipment claim had been denied by Medicare due to erroneous information submitted by her physician. With the SHICAP volunteer's help, a reconsideration was filed with corrected information certified by her physician. The \$2,575 bill was accepted, and paid promptly by her Medicare and Medigap coverages.

MARYLAND STATE OFFICE ON AGING
SENIOR HEALTH INSURANCE COUNSELING AND ADVOCACY PROGRAM (SHICAP)

The Senior Health Insurance Counseling and Advocacy Program meets one of the most universal and critical needs of older persons today. It offers face-to-face assistance and counseling with respect to many problems seniors encounter regarding health insurance. SHICAP provides services in the following four general areas:

* Health insurance claims assistance to seniors in connection with Medicare, Medigap and general health insurance carriers;

* Provides information about health insurance matters to seniors and their families through seminars, meetings, media reports, and other means;

* Helps seniors secure legal advocacy services when needed in connection with health insurance claims, appeals, and requests for reconsiderations;

* Assists seniors in selecting appropriate Medigap and/or long-term care insurance coverage.

Senior Health Insurance Counseling and Advocacy Program services are delivered by staff and volunteers who are trained, supervised, and monitored. The program is funded in 14 counties (more than half the state), and is operating in Baltimore County, Calvert, Carroll, Charles, Dorchester, Harford, Howard, Montgomery, Prince George's, Somerset, St. Mary's, Washington, Wicomico, and Worcester Counties. In FY 1990, approximately 3,400 clients were served, receiving assistance in Medicare and supplemental insurance claims matters and counseling. In addition, public education presentations reached over 8,100 individuals, and over 4,200 individuals were assisted over the telephone. There are about 150 volunteers serving as SHICAP counselors.

The Senior Health Insurance Counseling and Advocacy Program is a State-funded project, matched by some local funding. In FY 1991, State SHICAP grants totalled \$166,018, local matches added an additional \$54,845 for a total project budget of \$220,863 (this excludes State Office administrative costs).

The program has saved thousands of dollars for seniors by assisting them in filing their Medicare and health insurance bills and claims, and by helping them make difficult decisions regarding their health insurance needs.

For more information on SHICAP, contact: Michelle P. Holzer, SHICAP Coordinator, Maryland State Office on Aging, 301 West Preston Street, Room 1004, Baltimore, Maryland 21201; Telephone: (301) 225-1270 or Toll-free 1-800-AGE-DIAL.

Prepared Statement of D. Ty Duhamel

A fundamental purpose of legal services funded by the Older Americans Act is to insure that the frail, vulnerable elderly are able to protect and/or obtain the necessities of life to which they are entitled under law. The provision of "legal services" is not a goal unto itself. Rather, "legal services" are a means or a tool that enables vulnerable seniors to obtain sustaining income, food, health care, housing, and personal safety and independence. This presentation describes how a small, three-attorney legal services office in rural central Washington approaches the problem of serving the vulnerable elderly and, hopefully, in so doing, describe the need for continued and improved Older Americans Act support in the future.

Necessities of Life -- Older individuals with health or mobility problems, who were formerly productive citizens in the mainstream, often become dependent on governmental and private benefit programs. Many encounter legal problems involving indecipherable regulatory mazes and insurmountable bureaucratic obstacles. A vulnerable senior denied disability benefits because he did not have a birth certificate has no chance without legal assistance.

Others are required to fight in private arenas beyond their experience or ability to obtain previously earned benefits that are the necessities of old age. Elderly retirees whose former employer purchased health insurance at a cost "too good to be true" will need legal intervention when the health insurance company goes bankrupt. Otherwise, the senior employees are left without recourse when past, present, and future medical bills are not paid.

Safety and Independence --- The vulnerable elderly often lack the ability to protect their own interests and legal intervention may be required simply to provide protection. For example, a vulnerable elderly person who fails to make mortgage payments because of mental deterioration will be confronted with non-judicial foreclosure taking effect upon the senior's failure to respond to a series of mailed notices. With legal services' involvement, court proceedings will be initiated, the home saved, and unnecessary institutionalization avoided.

In more sinister situations, vulnerable adults may be preyed upon and exploited because of their inability to protect themselves. For example, a cocaine-addicted adult child may move in against an elderly parent's wishes. The child will then steal money, tools, food, and vehicles to support a drug habit. Cocaine may be stored and sold from the senior's home and the senior threatened into silent submission. With legal intervention a restraining order can be obtained compelling the abusive, addicted child to move out and not return.

Reaching Out --- Vulnerable seniors need a wide array of services to meet their immediate legal needs and to help them avoid future legal difficulties. Moreover, legal services bring together other professionals and non-professionals in putting together a comprehensive delivery system which maximizes available resources from both the public and private sector. The need for immediate legal needs and to avoid future problems is addressed by:

1. Counseling (in-office or in the senior's home);
2. Representing older persons in civil legal matters, such as public entitlements, housing, health insurance coverage; and
3. Informational activities, such as giving public presentations about financing nursing home care, public entitlement eligibility, and tools used to combat elder neglect, abuse, and exploitation.

Meeting the needs of as many seniors as possible is best met by:

1. Training private attorneys in areas of legal services' expertise, such as housing rights, Medicaid and Medicare, in exchange for future pro bono services;
2. Training non-lawyer advocates to help with financial planning and other public-benefit related issues; and
3. Training non-lawyer advocates to provide lay representation before administrative agencies when the stakes are small (Social Security overpayment or Medicaid cases).

Direct representation, training of lay and professional advocates, and public education are all essential components of an effective system to deliver legal services to the vulnerable elderly. All need to be emphasized in law and adequately funded.

IF YOU HAVE RECEIVED AN OVERPAYMENT NOTICE

This letter describes your rights and how to represent yourself when Social Security notifies you of an overpayment on your Social Security (Title II) benefits. Unfortunately, Evergreen Legal Services does not have the resources to represent people with Social Security overpayments. However, this letter will tell you how to challenge or repay your Social Security overpayment.

There are several reasons why the Social Security Administration may claim you are overpaid. Some common reasons are: Social Security made an error, Social Security did not know about something that should have reduced your benefits, you received benefits while appealing a decision and you lost, or you failed to file an Annual Earnings Report on time. No matter what the reason for the overpayment, Social Security can require you to repay it, with only some exceptions (discussed below).

You have the right to be told in writing how much money you owe, what action Social Security will take, and the amount of time you have to request a waiver or an appeal. You must get a notice even if you have already agreed to repay the money.

Please Note: If you are the sponsor of a person who is an alien, there are special rules for overpayments. You should call your Social Security office or Evergreen Legal Services for more information.

WHAT YOU CAN DO WHEN YOU GET AN OVERPAYMENT LETTER.

(1) IMPORTANT: If you do nothing else, request a minimum rate of repayment! Make sure to notify the Social Security Administration, in writing, that you can only repay a limited amount of money each month. [Otherwise 10% of your check will be cut off.] You should notify the Social Security Administration right away, regardless of whether you request an appeal or waiver, or are going to voluntarily repay the money.

Use the following statement:

Regardless of any future determination, if and when a recoupment of benefits begins, I request a rate of repayment of no more than \$_____ per month. [Name, Social Security Number]

(2) Request reconsideration and/or a waiver.

In addition to requesting a low rate of repayment, you can take two actions to challenge the overpayment: You can request a reconsideration and/or a waiver. A reconsideration is a challenge to Social Security's decision that you were overpaid or the amount of the overpayment. A waiver is a request that you not be required to repay the money, even though you were actually overpaid. Make your request in writing, keep a copy, and ask Social Security to send you any necessary forms to fill out. You may request both reconsideration and waiver at the same time.

THE RECONSIDERATION PROCESS

If you do not think that you were overpaid or disagree with the amount of the overpayment, then you can request a reconsideration. Social Security will review the overpayment to see if it is correct.

You have 60 days after you receive your overpayment letter to request a reconsideration. (Generally, Social Security presumes you received your letter 5 days after the letter was dated. So you have a total of 65 days from the notice date to request reconsideration.) If more than 60 days have passed, you can still request a reconsideration if you have "good cause" for the delay.

If you request reconsideration within 30 days after receiving your notice, Social Security will not take any money out of your check, or ask you to pay anything until the reconsideration decision is made. You can still request a reconsideration after 30 days even if Social Security has begun to take money out of your check. Social Security will stop recouping once you appeal. But money already recouped will usually not be returned to you until you win your appeal.

You have the right to present additional evidence for reconsideration and to review Social Security's evidence (ask for photocopies). The reconsideration decision can be made in two ways: (1) a file review, where you are not present, and (2) a personal conference where you go to the Social Security Office and explain your case. You have the right to choose either one. A personal conference gives you a better chance to explain your position. You can take witnesses to support your position and you will talk face-to-face with the person making the decision.

If you lose the reconsideration, then Social Security will start to recoup the overpayment from your benefits or ask you to start repaying the money (if you are not still on Social Security). This is true even though you appeal your case further through the appeals system. (The appeals system is explained below.) For information about appealing the decision, turn to page 4.

THE WAIVER PROCESS

You may request a waiver at any time! To qualify for a waiver you must show two things: (1) that you were "without fault" in causing the overpayment, and (2) that repayment would cause a hardship to you or "be against equity and good conscience."

1. "Without Fault"

To prove that you are "without fault", you must show that you did not do anything knowingly (on purpose) to cause the overpayment and that you did not use the benefits knowing that you were not eligible for them. When Social Security decides whether you are "without fault" they must consider your understanding of the reporting requirements and the rules, and your efforts, opportunities, and abilities to comply with those requirements. Also, any other circumstances that might explain your actions will be considered. Social Security's current policy is to grant automatic waivers of overpayments of \$100 or less, when requested.

2. Financial Hardship or Against Equity and Good Conscience

To prove that repayment would cause you hardship or is against good conscience, you can either show that your ordinary monthly living expenses are equal to or greater than your monthly income, or, that you believed you were entitled to the money you received and you changed your circumstances because of the money (e.g., you moved into a more expensive apartment or turned down other assistance). If either of these conditions exist, then it would not be fair for Social Security to require you to repay the overpayment.

Enclosed are the waiver regulations which explain these requirements in more detail. [20 C.F.R. 416.550-.555.]

Again, you may request a waiver at any time! There is no time limit. When you request a waiver, you must fill out an "Overpayment Recovery Questionnaire." If you file for a waiver within 30 days of the date of the overpayment letter, Social Security will not take any money out of your check. But no matter when you request a waiver, Social Security must stop recouping money and will reinstate your monthly check at the pre-overpayment level until the waiver and personal conference decisions are made. Money already taken out of your benefits check will not be returned unless you win the appeal.

3. Reconsideration if Waiver Denied

If Social Security denies your request for a waiver, then you may request a reconsideration within 60 days of the denial date. The reconsideration process is described above. You can present evidence, testify, have witnesses testify, and look at Social Security's evidence. At the reconsideration conference, you will discuss why you are "without fault" and cannot repay the money.

Based on this conference the decisionmaker will determine whether you have met the requirements for a waiver. If they decide in your favor, Social Security will not take any more money from your benefit check and will return any money taken out so far. If you lose the waiver decision, then your benefits will be withheld or reduced to recover the overpayment, regardless of whether or not you appeal the decision. If you requested a reduced adjustment, then that is what the Social Security will take out of your check.

If you lose the reconsideration decision you may appeal. The appeal process is described below.

THE ALJ HEARING AND FURTHER APPEALS

If you lose your reconsideration or waiver, you have the right to request a hearing within 60 days of the unfavorable decision. This is an oral hearing before an ALJ. At this hearing, you have the right to present evidence, cross-examine witnesses, and to see your file. These hearings are held at the Federal Building in Seattle.

The hearing is informal and there is no representative there for the Social Security Administration. You may represent yourself or have someone else represent you.

You will get a written decision from the ALJ. If you are dissatisfied with the decision, you may appeal to the Social Security Appeals Council. This appeal request must be written. You can submit this request to any Social Security office or to the Appeals Council. You must file this appeal within 60 days of the date of the ALJ's decision. Not every case is reviewed because the Appeals Council has wide discretion in deciding whether to review a case.

If you are dissatisfied with the final agency decision you received (the Appeals Council refuses to review your case or does not decide in your favor), you may appeal through the U.S. District Court. This appeal must be filed within 60 days of the Appeals Council decision or denial of review.

IF YOU LOSE--/FORM OF REPAYMENT

If you lose your reconsideration and your waiver requests, then Social Security will request that you repay the amount you were overpaid. Social Security can request repayment in one of two ways:

- (1) a direct refund
- (2) an adjustment of your current benefits.

Social Security can collect from the person who received the overpayment or, if that person is dead, from his or her estate.

IF YOU ARE STILL RECEIVING SSI

Usually, repayment is made through a reduction of your monthly benefits or the benefits that others received on the same work record. Social Security will recoup 10% of your monthly benefits unless you request a more gradual repayment plan (see the sample notice at the beginning of this letter).

If you have not done so already, you should put your request for a repayment plan in writing within 30 days of your unfavorable decision.

You may request a repayment plan at the time you first request the waiver. However, the plan would not start until your reconsideration or waiver decisions are made. If you make your plan early and Social Security rejects the plan, you can appeal that decision along with your reconsideration and waiver appeals.

The only time Social Security will not consider a reduced payment plan is if your notice claims that your "fraud or similar fault" caused the overpayment.

When you submit a repayment plan, tell Social Security how

much you can afford to repay each month. Also, explain why you can only afford these payments. Social Security will usually take 10% of your monthly benefit. But if you can show that you are financially unable to pay that much, they may accept an offer to pay \$1.00 to \$10.00 per month. Social Security may tell you that they want you to repay in just 36 months (3 years). But they will probably accept any reasonable offer to repay. Social Security will consider how much money you need each month to meet your living expenses. You should not have to make payments that prevent you from meeting those expenses.

IMPORTANT: Social Security cannot deduct an SSI overpayment from non-SSI Social Security Benefits (Title II or other benefits such as Old Age or Disability insurance) unless you voluntarily agree to do this in writing. Do not sign any agreement unless you want to repay the SSI overpayment directly from your Social Security check. Social Security also cannot deduct a non-SSI overpayment from your SSI check.

IF YOU ARE NO LONGER RECEIVING SSI BENEFITS

If you are no longer receiving SSI benefits and do not expect to do so for the next few months, then you may "compromise" your overpayment. This means that you offer to repay less than the full amount of the overpayment. Social Security will accept a compromise offer because it is costly for them to go to court to recover the overpayment from you. Social Security will not let you compromise if (1) you have the money you were overpaid, or (2) you were found to have fraud or "similar fault" causing the overpayment.

You should make your offer in writing and send it to any Social Security office. Your letter should include your name, Social Security number, the amount of the overpayment, the amount you want to repay, and why you are unable to pay back the full amount, if this is the case.

Social Security will accept offers to repay 60% - 80% of the overpayment. They may accept less than 60% if your overpayment is not large (e.g., less than \$5,000) and you show that you are financially unable to pay more than what you have offered. You have the right to negotiate a compromise settlement and to repay the debt in monthly installments rather than all at once. Social Security will encourage you to repay the debt in one lump sum, but you do not have to do that if you are financially unable.

If your compromise offer is rejected, you should immediately submit a new offer. If the Social Security makes a counter-offer you can accept it or reject it to make your own counter-offer. When you reach a settlement, you must begin to repay part or all of the overpayment within 30 days, unless you arrange in writing for more time.

Declaring bankruptcy is a last resort, and may require legal help. If you need more information on bankruptcy, call Evergreen Legal Services.

If you need further information on overpayments or assistance with your case, please call Evergreen Legal Services.

OVERPAYMENT CHECKLIST--SSI

- What is the date on the overpayment notice? _____
- Write Social Security and request reduced recoupment!
- Did you request a reconsideration within 30 days of that date?
- Did you request a waiver within 30 days of that date?
- If you did not request either a reconsideration or waiver within 30 days, then recoupment will begin automatically.
- You may still request a reconsideration within the next 30 days (60 days from the notice) or later if you have "good cause". A request for reconsideration will stop recoupment until the decision is made.
- You may request a waiver at any time! A request for a waiver will stop recoupment until after (1) the waiver is denied initially and (2) the waiver is still denied after a person conference.
If you request a personal conference within 10 days there will be no recoupment between the last waiver denial and the personal conference.
- If Both (or either) waiver and reconsideration were decided against you. Recoupment will begin.
- You may appeal your reconsideration or waiver decision within 60 days to an ALJ or go to the hearing.
- If you lose the hearing, you can appeal within 60 days to the Appeals Council and, within 60 days of that decision to the U.S. District Court.
- If you are still receiving benefits request a reduced recoupment, if you haven't already. Social Security will take 10% of your monthly income to repay your overpayment. But you may ask them to take less each month.
- If you are no longer receiving benefits, write or offer a compromise settlement.

THE MEDICALLY NEEDEY ("SPEND-DOWN") PROGRAM FOR SENIOR CITIZENS

PREPARED BY EVERGREEN LEGAL SERVICES

Revision: January 1, 1991

INTRODUCTION

The Medically Needy Program helps pay medical expenses for low income senior citizens and for disabled people who do not receive Medicaid coupons as part of an SSI, General Assistance or other public assistance grant. The full name of the program is "Limited Casualty Program-Medically Needy," abbreviated "LCP-MN." It is run by the Department of Social and Health Services ("DSHS"). Under this program, you can receive Medicaid coupons after you have spent part of your income on medical expenses.

(This brochure only discusses the program for people who are 65 or older, or who are disabled. Certain families with dependent children and pregnant women may also qualify for LCP-MN under somewhat different rules.)

WHO CAN GET MEDICALLY NEEDEY BENEFITS?

You may be eligible for benefits if:

- ▶ you are 65 or older, or blind or disabled,
and
- ▶ your income and property (resources) are very limited.

HOW MUCH PROPERTY CAN I HAVE?

You can have a house (if you live in it) and basic household items and personal belongings. In addition you can have cash, bank accounts and other similar property up to a limit of \$2,000 for an individual or \$3,000 for a couple. And you can have an automobile worth up to \$4,500 wholesale value. (If your car is needed for transportation to employment or medical treatment, is modified for use by a handicapped person or is needed for essential daily activities because of climate, terrain or distance, then there is no limit on its value.)

HOW MUCH INCOME CAN I HAVE?

There is no restriction on how much income you can have. What matters is how much income you have left after paying medical expenses. DSHS rules allow a single person to keep \$458 to pay for non-medical living essentials (food, shelter, clothing, etc.). A couple applying together may keep \$575. When only one member of a couple applies for coupons, the couple is allowed to keep \$916.

Any income over these amounts is considered to be available for paying your

own medical bills. For example, a person with \$468 monthly income after allowable deductions (see the attached worksheet) has \$10.00 (\$468 - \$458 = \$10) left over each month to pay for needed medical care. DSHS calls this \$10.00 "excess income."

WHAT IS A SPEND-DOWN?

The spend-down is simply the amount of your "excess income" you must spend on medical expenses before you can receive benefits. You can choose a spend-down period of either three or six months. After you use up your "excess income" to pay for medical expenses, the Medically Needy Program will step in and cover most of your remaining medical expenses.

In a way, the spend-down works like a "deductible" in a standard health insurance policy. Your own particular deductible will be equal to the amount of your "excess income." First, you are responsible for meeting this spend-down deductible and then, after Medicare or other insurance has paid their portion, the Medically Needy Program will pay the rest.

To figure out the approximate amount of your spend-down obligation, use the budget worksheet at the end of this guide.

WHAT WILL THE MEDICALLY NEEDEY PROGRAM COVER?

After you have met your spend-down obligation the Medically Needy Program will cover the following medical services:

- Physician Services
- Inpatient Hospital Services
- Prescribed Drugs
- Outpatient Hospital Services
- Rural Health Clinic Services
- Adult Dental Care (including dentures)
- Clinic Services
- Home Health Care
- Prosthetic Devices
- Laboratory and X-ray Services
- Eyeglasses
- Nursing Home Care

The cost of your transportation to your doctor's office or the hospital to receive treatment may also be paid by the Medically Needy Program.

HOW DO I APPLY FOR THE MEDICALLY NEEDEY SPEND-DOWN PROGRAM?

- 1: Fill Out The DSHS Form. You must fill out a Medically Needy application at a local office of the DSHS. You should receive an answer within 30 days. If you have "excess income," the notice should state the amount of your spend-down obligation for the three or six month period.

- 2: Collect and Turn in Copies of All Medical Bills to DSHS. You continue to go to the doctor or get medication, as necessary. Once you have run up medical expenses equal to the spend-down amount, you show the bills and the Medicare or other insurance payments to the financial worker at the local DSHS office. The DSHS office will issue you a medical coupon for the remainder of the three or six month period. You can then use the medical coupon for medical expenses incurred after the date shown on the coupon.
- 3: Reapply Every Three or Six Months. At the end of your spend-down period, you must re-apply and begin the process again. You should not have to actually go to the DSHS office to re-apply, but can call, requesting that an application be sent to you. When you have completed the form, you can send it back by mail. The DSHS office will notify you of your spend-down obligation. Once you have met it, coverage begins again for another three or six month period.
1. You must only show that you have incurred expenses not covered by Medicare or other insurance. You do not have to show that you have actually paid the bills.
2. The starting date of the spend-down period will usually begin with the month you apply.
3. If you have incurred large medical bills in the three months preceding your application, you should ask for retroactive coverage to cover expenses already incurred.
4. You should keep copies of all papers showing medical expenses and insurance reimbursements.

(This includes bills for doctor visits, prescription medication, hospital and nursing care. It also includes expenses that are not usually covered by private medical insurance, such as medically necessary transportation. If you have health insurance, including Medicare, the cost of your premiums can be counted, including the premiums you expect to pay later in the three or six month computation period. If the amount of your spend-down is less than the cost of your private health insurance premiums, you should seek advice from Senior Information and Assistance for help in analyzing the cost and coverage of

HOW CAN I MEET MY SPEND-DOWN OBLIGATION?

The following are some important tips to keep in mind when presenting your application and attempting to meet your spend-down obligation.

your present policy and the potential advantages and/or disadvantages of dropping your present health coverage.)

5. If at all possible, use your money to purchase medical services that the Medically Needy Spend-Down Program will not cover. Then use the medical coupons to purchase services covered by the Medically Needy Spend-Down Program.

medical care. They will bill DSHS directly for the full cost of the services. When you use your medical coupon for drugs or services, you should not be obligated to pay any part of the cost.

Remember that you must go to a medical care provider who accepts medical coupons. Check with your doctor or pharmacist to make sure they accept medical coupons before you receive any care.

WHEN I DO GET MY MEDICAID COUPONS, HOW DO I USE THEM?

Give a medical coupon to your doctor, nurse or pharmacist each time you need

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MEDICALLY NEEDED SPENDDOWN WORKSHEET FOR SENIOR CITIZENS (SSI-RELATED)

- A. **UNEARNED INCOME** (This includes Social Security, Veterans, and other employment pensions, interest from savings, etc.)

1. State your total Unearned Income received each month from all sources. _____
2. Subtract \$20.00 - 20.00
3. Total Unearned Income: = _____

- B. **EARNED INCOME** (This includes gross earnings from work or training and net earnings from self-employment.)

1. State your total gross earnings (amount before withholding) from your work or training. _____
2. Calculate net earnings from self-employment. (Net earnings is the monthly amount of money received after all business expenses are subtracted.) _____
3. Add gross earnings (B.1) and earnings from self-employment (B.2) _____
4. Subtract \$65.00 - 65.00
5. Subtotal (All earnings less \$65.00) _____
6. Divide your answer in 5 above by 2. _____
7. Subtract \$20.00 if no unearned income (A above) or if did not subtract \$20.00 in A.2 above. _____
8. Total Earned Income: = _____

C. **COUNTABLE INCOME** (This is the amount that will be used to determine your Medicaid Eligibility.)

1. Total Unearned Income (A.3). _____
2. Total Earned Income (B.8). _____ + _____
3. Total Countable Income (Add Total Unearned and Earned Income): _____ = _____

D. **DETERMINE MEDICAID ELIGIBILITY**

1. Compare your Countable Income (C.3) to the Medicaid income standards in the table below. (Note: Make sure that you use the figure corresponding to the number of persons in your family applying for Medicaid.)

<u>Number of Persons</u>	<u>Amount</u>
One person	\$458
Couple applying together	575
Couple with only one spouse applying (each spouse has a separate \$414)	916

2. If your Countable Income (C.3) is less than the Medicaid Income standards, you are eligible for Medicaid. **APPLY**
3. If your Countable Income (C.3) is more than the Medicaid income standards, Calculate your Spend-Down obligation.

E. **CALCULATE SPEND-DOWN OBLIGATION**

1. State your Countable Income (C.3) _____
2. Subtract the amount of the Medicaid income standard from the table above (D.1) that fits your circumstances. _____ - _____
3. Result is "Excess Income": _____ = _____
4. Multiply your Excess Income by 3 if you are using a 3 month period (multiply by 6 if using 6 month period). _____ x _____
5. Result is Spend-Down Obligation for spenddown-period: _____ = _____

NOTE: Apply for benefits if you think your medical expenses for the three month period will be more than what your spenddown obligation is for the three month period.

QUESTIONS AND ANSWERS ON MEDICAID FOR NURSING HOME RESIDENTS

PREPARED BY EVERGREEN LEGAL SERVICES

Revision: January 1, 1991

WARNING: The information given here is accurate as of the date of this revision. The rules can and do change. If you are contemplating transferring resources or are concerned about the application of these rules to your situation, you should obtain individualized legal advice.

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**QUESTIONS AND ANSWERS
ON MEDICAID FOR
NURSING HOME RESIDENTS**

I. WHAT IS MEDICAID?

Medicaid is a state and federally funded program that pays for nursing home care. You apply for Medicaid at your local office of the Washington State Department of Social and Health Services (DSHS).

If you are eligible for Medicaid, DSHS will tell you how much of your monthly income to pay to the nursing home. Medicaid will pay the rest of the cost.

**II. WHAT ARE THE BASIC
MEDICAID FINANCIAL
ELIGIBILITY REQUIREMENTS
FOR NURSING HOME CARE?**

Both your income and your resources must be within limits set by law. Income includes such things as Social Security, VA benefits and wages. Resources include such things as real estate, bank accounts and stocks.

A. Income

Your monthly income must be less than the total of (1) the State's Medicaid rate for nursing home care plus (2) your regular monthly medical expenses. (The Medicaid rate for nursing home care — the rate charged for Medicaid patients — varies with each home. The rate can be obtained from the nursing home or by calling the Department

of Social and Health Services at 1-800-422-3263.)

Example:

Seaside Nursing Home	
Medicaid rate	= 1600
Your regular monthly	
pharmacy bill	= <u>35</u>
	1635

If your monthly income is less than \$1,635, your income would be within the Medicaid eligibility limit.

Also, if your income is not enough to pay the amount charged by the nursing home for non-Medicaid residents, you may be eligible for Medicaid even if your income is greater than the Medicaid nursing home rate plus your regular medical expenses. If you apply and are eligible on this basis, the nursing home will charge you only the lower Medicaid rate.

For married couples where one spouse enters a nursing home, there are special rules about income. These rules are explained in Section III below.

B. Resources

Your resources (assets or property) cannot be worth more than \$2,000. Certain "exempt" resources are not counted in determining whether you fall within these limits. Exempt resources are described in Section V below.

For married couples when one spouse enters a nursing home and applies for Medicaid, there are spe-

cial rules about resources. These rules allow a spouse at home who is not on Medicaid to keep substantially more resources. These rules are explained in Section IV below. Rules about giving away your property are described in Section VI below.

III. WHAT INCOME CAN I KEEP IF MY SPOUSE GOES INTO A NURSING HOME?

When one spouse goes into a nursing home, Medicaid allows the spouse who remains at home to keep certain income.

If you remain at home while your spouse is in a nursing home, you may keep the greater of:

- (1) All income paid in your name,

or

- (2) All income paid in your name plus as much of your spouse's income as is necessary to bring your income up to \$1,258 per month. And, if your housing costs (rent or mortgage, taxes, insurance, and utilities) exceed \$256.80 per month, the \$1,258 level can be increased up to \$1,662 by the amount of this excess. (In calculating housing costs, your actual costs for rent, mortgage, taxes, and insurance are used. For utilities, however,

a standard figure of \$120 per month is used.)

Examples:

If \$1400 is payable in your name and \$600 is payable in your spouse's name, you can keep \$1400. If \$600 is payable in your name and \$1400 is payable in your spouse's name, you can keep your \$600 plus at least \$658 of your spouse's income ($\$600 + \$658 = \$1,258$). And if your housing costs are \$306.80 per month, you can keep \$708 of your spouse's income ($\$600 + \$658 + 50 = \$1,308$) because the \$1258 level is increased by the excess of your housing costs over \$256.80 ($\$306.80 - \$256.80 = \$50$).

A spouse at home may also be entitled to an additional allowance for the care of a dependent family member.

IV. WHAT RESOURCES CAN I KEEP IF MY SPOUSE GOES INTO A NURSING HOME?

A. Rules when spouse entered nursing home before September 30, 1989

The following rules apply for all married couples when one spouse has continuously resided in a nursing home (whether or not on Medicaid) since before September 30, 1989 (or was continuously on the COPES program since before September 30, 1989):

- (1) If your spouse is in a nursing home, your separate property is not considered when determining the Medicaid eligibility of your spouse. However, your spouse cannot own more than \$2,000.
- (2) A married person may transfer any resource to a spouse in order to come within the \$2,000 resource limitation to be eligible for Medicaid. There is no limit on how much your spouse can transfer to you and a divorce or legal separation is not necessary to make an effective transfer. However, it is advisable to consult a lawyer because the transfer may require signing a deed or other documents and may affect your tax obligations. Also, it is often a good idea to revise wills or community property agreements when making a transfer of resources.
- (2) The spouse at home will be allowed to keep resources having a value of up to \$66,480 no matter which spouse owned such resources. (A transfer of resources to the spouse at home may be required after Medicaid coverage is approved.) In addition, the spouse at home can keep all resources that are "exempt" under the rules described in Section V below, and there is no limit on the value of a car, household goods, or personal effects that the spouse at home can keep.
- (3) The spouse at home may be allowed to keep more than \$66,480 worth of non-exempt resources if the income of the spouse at home is less than what the spouse is entitled to under the rules explained in Section III above (\$1,258 to \$1,662). To get this, the spouse must obtain a hearing decision from DSHS that more resources are necessary to produce the permitted income level.

B. Rules when spouse enters nursing home after September 29, 1989

If your spouse goes into a nursing home after September 29, 1989, the following rules apply:

- (1) All resources of both spouses will be considered together. It will no longer matter which spouse owns what resources or whether a resource is community or separate property.

V. WHAT RESOURCES ARE NOT COUNTED IN DETERMINING MEDICAID ELIGIBILITY?

A. What are exempt resources?

Some resources are considered exempt and, therefore, are not counted toward the \$2,000 and \$66,480 re-

source limits. Exempt resources can include your home, household goods and personal effects, real estate sales contracts, a car, life insurance with a face value not more than \$1,500, most burial plots and prepaid burial plans, and certain other property and items used for self-support. Some of these are described in more detail below.

Also, note that some *non-exempt* resources that cannot be quickly sold are disregarded until they are sold.

B. When is a home exempt?

As long as a Medicaid recipient, a spouse or, in some cases, a dependent or disabled relative, continues living in the home, the home is an exempt resource.

If you go into a nursing home and have no spouse or other dependent or disabled relative living in your home, the home will still be exempt if you state that you intend to return to it. You may also be entitled to have up to \$180 per month of your income set aside for up to six months to maintain your home while receiving Medicaid benefits for your nursing home care.

C. When is a sales contract exempt?

As of October 1, 1990, the seller's interest in a real estate sales contract is an exempt resource. However, all interest and principal payments received as a result of holding such a contract will be treated as unearned income.

D. When is a car exempt?

If your spouse is in a nursing home, your car is exempt no matter how much it is worth or how it is used.

E. When is life insurance exempt?

Life insurance is exempt if the total face value (the amount payable at death) of the policy or policies is not more than \$1,500. If married, each spouse may have \$1,500 of life insurance. If the face value of an individual's life insurance is more than \$1,500, the entire cash surrender value (the amount the life insurance company will pay if the policy is cancelled) is counted as a non-exempt resource. (This means it will count as part of the \$2,000 allowed for resources.)

F. When are burial funds and spaces exempt?

A burial fund of \$1,500 for an individual (and an additional \$1,500 for a spouse) is exempt if it is set aside in a clearly designated account to cover burial expenses. If an individual has life insurance, the face value of the life insurance will count as part of the individual's burial fund. So, for example, if a Medicaid recipient has life insurance with a face value of \$1,000, then only \$500 may be exempted in a designated account for burial expenses.

An irrevocable trust may be created for burial expenses and the entire amount of such a trust, no matter how large, is exempt. However, any funds in such a trust will count

against the exemption for burial funds or life insurance.

Burial spaces for a Medicaid recipient and for immediate family members are exempt no matter how much they are worth.

G. When are household goods and personal effects exempt?

If your spouse is in a nursing home, your household furniture, other household equipment, as well as clothing, jewelry and personal care items are exempt no matter how much they are worth.

VI. CAN I GIVE AWAY ANY PROPERTY WITHOUT AFFECTING MY MEDICAID ELIGIBILITY?

WARNING: The Medicaid rules on transferring property are very complicated and the penalties for prohibited transfers are severe. What follows is only a summary and you should not attempt transfers without getting legal assistance.

A. Rules for transfers to a spouse

There is no Medicaid penalty if you transfer property to your spouse before you apply for Medicaid Nursing Home coverage. However, if you don't go into a nursing home until after September 1989, the resources of both husband and wife will be considered together in determining Medicaid eligibility. See Section IV.B. above.

B. Rules for transfers to non-spouses made after June 1989

The following rules apply to transfers made after June, 1989:

(1) A home may be transferred without penalty only to:

► A spouse,

or

► A child who either:

is under 21, or is blind, or is permanently and totally disabled,

or

has lived in the home and cared for the parent for two years before the date of the parent's institutionalization,

or

► A brother or sister who has an equity interest in the home and who has lived there for at least one year immediately before the date of their sibling's institutionalization.

The person making the transfer does not need to live in the home at the time of the transfer to one of the above people.

- (2) Exempt resources (described in Section V) other than the home or a sales contract may be transferred to anyone without penalty.

- (3) Transfers of non-exempt resources, sales contracts, or a home to someone other than the persons listed above, for less than fair market value within 30 months of applying for Medicaid may result in a period of ineligibility. The length of the period of ineligibility depends on the value of the resource given away (specifically, the number of months of ineligibility is the value of the gift divided by \$2036), but it cannot be more than 30 months.

The period of ineligibility can be avoided by showing that the transfer was not made to qualify for Medicaid, and may be waived where DSHS finds it will cause undue hardship.

If you wait at least 30 months after you transfer resources to apply for Medicaid, there will be no period of ineligibility.

- (4) Generally, the same restrictions apply to transfers by either you or your spouse. This means that if you or your spouse give away excess resources it may result in a period of ineligibility for you. This is a very com-

plicated area and legal advice is essential.

C. Rules for transfers to non-spouses made before July 1989

For transfers of property before July 1989, the following rules apply:

- (1) If you transferred exempt property (such as your home while you are living in it — see Section V above) to any person before July 1, 1989, it will not affect your Medicaid eligibility.
- (2) If you transferred non-exempt property before July 1989 to someone other than a spouse, you may be ineligible for Medicaid for up to 24 months from the date you gave away the property.
- (3) There is no penalty if you sell your property for a fair price. This is also no penalty if you give away your property but it was not for the purpose of becoming eligible for Medicaid.

VII. CONCLUSION

The rules governing Medicaid eligibility are complicated. Before taking any steps you don't fully understand, you should get individualized legal advice.

Prepared by Evergreen Legal Services
401 Second Ave. South, Suite 401
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EVERGREEN LEGAL SERVICES

NORTH CENTRAL REGIONAL OFFICE (WENATCHEE)

1990 SENIOR SERVICES SUMMARY

Evergreen's NCR office consists of three attorneys (Kelly Owen, Alan Marriner and Ty Duhamel) and provides legal services to seniors (age 60 and over) in Chelan, Douglas, Okanogan, Grant, Lincoln and Adams counties. The office receives a special grant from the Columbia River Area Agency on Aging that guarantees enhanced services to seniors. Senior services are targeted to address the vital human needs of the elderly: health care access, adequate income, proper food and nutrition, quality housing, protection from homelessness, freedom from abuse and exploitation, and remaining independent to the maximum extent possible. The following cases illustrate how legal services help older individuals meet these vital human needs.

1. Phettiplace v. Phettiplace (Grant County Superior Court No. 90-2-00376-7): The North Central Regional office represents an elderly stroke victim who was being abused and exploited by a cocaine-addicted adult son. The son moved into a camper located in the senior's front yard and took the senior's money, tools, food, and truck. A Vulnerable Adult Protection Order, available under RCW 74.34.130, was obtained and the son was prohibited from contacting his father for a period of one year and from taking the father's property. The father's truck was returned after the son was arrested.
2. In Re Guardianship of Leonard Schons, Jr. (Chelan County Superior Court No. 12145): Evergreen Legal Services represents a mentally disabled, 61 year-old man who is subject to a court-ordered guardianship. The guardian appears to have misappropriated \$92,000 from the client's estate and was keeping the client's monthly Social Security checks. The case came to Evergreen when the client was over \$3000 in arrears on payments to his residential care facility. Evergreen obtained an Temporary Restraining Order prohibiting the guardian from interfering with the client's estate. Later, a Permanent Restraining Order was obtained and the guardian removed. The county prosecutor is presently considering criminal prosecution. The \$92,000 may be lost, but the Social Security checks are now going towards the client's care.
3. Wilson v. Sullivan, (Federal District Court, Eastern District of Washington, C-89-531-RJM): A senior must be able to prove date of birth in order to qualify for Supplemental Security Income benefits. Date of birth is proven by birth certificates, bible records, etc. Difficult problems arise when such records do not exist. This senior has some age documentation but lost his hearing on the grounds that the records were not sufficient. This meant that the client could not receive SSI benefits until he proved disability, a difficult task when the senior is relatively healthy. Evergreen appealed to federal court and recently the Social Security Administration agreed that the client's evidence was sufficient. Future benefits and two years' back benefits have been awarded.
4. In Re G.: Evergreen's client transferred several thousand dollars to her children before entering a nursing home. The transfer was made on the advice of non-ELS counsel. When DSHS found out about the transfer one year later it determined the transfer invalid, and decided that the senior still owed the money and had been ineligible for nursing home benefits for a full year. This decision, if left standing, would have left the senior with a nursing home bill of approxi-

mately \$25,000 and threatened her continued care. Evergreen was able to persuade DSHS that its decision was wrong, that the transfer had been valid, and that the case should have been treated as a transfer-of-asset problem. Under the Transfer of Asset rule, the inappropriate transfer resulted in two months of ineligibility and a two-month overpayment. The client will have a \$4000 overpayment; the net benefit to the client will be approximately \$21,000. The overpayment will be paid by the client's children out of the funds transferred to them.

5. Chrysler First v. Manning (Grant County Superior Court No. 89-2-003429): Evergreen's North Central Regional office is representing two senior citizens who were sold a water softening system for \$4000. The door-to-door salesman talked about lead and other chemicals in local water supplies, implied that the seniors' health was endangered and stayed until 12:30 a.m. when the contract was finally signed. After installation the system promptly broke down and the company refused to make any repairs. The seniors refused to make payments and were sued by the contract assignee. Evergreen's clients allege fraudulent and deceptive sales practices, breach of warranty, and Consumer Protection Act violations.
6. Q169422 - A 78-year-old senior wrote Evergreen for help because she had been living below the poverty line since her husband died five years ago. After a short conversation it became clear that this widow was eligible for Veteran's "Aid and Attendance" benefits because her husband was an honorably discharged veteran. She is eligible for approximately \$215 per month to supplement her Social Security check. If not eligible for Veteran's benefits, she is eligible for SSI and medical assistance. It is unfortunate that it took so long for this woman to receive assistance with this problem.
7. Q169417 - Evergreen's client was denied entry into low-income senior housing because of the senior's mental illness. The apartment complex's decision violates the 1988 Amendments to the Civil Rights Act. The client is 80 years old, an excellent housekeeper, and does not disturb her neighbors. Evergreen has asked for the project's records and will appeal its decision to deny housing.
8. Q169401 - Evergreen's was sold a living trust by a door-to-door salesman. The trust, which was inappropriate for the senior's needs, cost \$1100. Because the client had significant resources, Evergreen referred client to private counsel and the State Attorney General.
9. Q169349 - Couples that receive Supplemental Security Income are treated as a single unit for payment purposes even though they may be separated. This policy continues for the first six months of separation. If the couple notifies the Social Security Administration that the separation has occurred, the Social Security Administration will simply split the SSI check and send half to each. This frequently leaves one or both spouses with insufficient income. This is particularly true when one spouse has other income, the SSI check is small, and splitting the SSI results in one spouse getting a minimal income. In this case, Evergreen's client was trying to live on approximately \$250 per month even though she and her husband had been separated for nine months. Evergreen provided advice and assistance about letting the Social Security Administration know how long ago the separation had occurred (SSA thought the separation was recent). The right questions had not been asked when Evergreen's client had originally notified the Social Security Administration of her separation.

10. 0112463 - Evergreen represents a 60-year-old Spanish-speaking farmworker whose unemployment benefits have been garnished by the Office of Support Enforcement. Fifty percent of his \$340 per month unemployment benefits are seized every month. OSE was garnishing for back support, which included a seven-year period after the senior's divorce when the senior lived with and supported his ex-wife and children. Evergreen's representation resulted in the senior's back support being reduced from \$3800 to \$900 and with OSE agreeing to reduce its garnishment to 15 percent of the senior's monthly unemployment benefits.
11. 0169327 - Evergreen's client requested information about a living trust. Services to set up a living trust had been purchased from a door-to-door salesman for \$1300. The device was inappropriate for a low-income senior, the salesman was informed of Evergreen's involvement, and refunded the money. Evergreen advised the client about estate planning for low-income senior citizens.
12. 0116964 - Evergreen helped an 86-year-old senior suffering from mental deterioration who had failed to make payments on a mortgage. The holder of the mortgage began foreclosure proceedings. Evergreen was able to delay the sale, obtain the appointment of a guardian by the superior court, and helped the guardian arrange the sale of the senior's land (reserving a life estate so the senior could remain in his home for the rest of his life). This file had been recently closed to the client's satisfaction.

Prepared Statement of Patricia K. Lashway

Protecting the rights of elderly is the mission underlying all of the services to the elderly. Reauthorization of the Older American Act will continue to allow our aging population to pursue life with the dignity they deserve.

The following recommendations are made in an effort to strengthen the advocacy roles as established in the Act:

- The Administration on Aging should be placed in a position within the federal organization that will allow better coordination with other federal agencies such as the Health Care Financing Administration and the Department of Labor in an effort to avoid duplication of reporting and data collection requirements, gaps in service delivery, and development of programs to meet the needs of the elderly.
- The role of the legal services developer should be strengthened and better defined to require each state to employ a person whose function is to provide leadership in developing the legal assistance and advocacy network. Minimum duties such as the development and coordination of legal assistance delivery models, development of statewide advocacy training, and the development of private bar programs should be required.
- Legal assistance would be strengthened by clarification of the definition to require each Title IIIB provider to provide court and administrative hearing representation.
- The statute should require legal assistance to focus on cases involving "survival issues" such as income maintenance, housing, food, and health care.
- Legal assistance should be funded under a new title to alleviate competing with service providers who may be the subject of client concerns.

- * The statute should better define the standard for the State Unit on Aging to grant a waiver for the funding of legal assistance.

Advocates within the Aging Network should not stop advocacy at the nursing home door. The statute must encourage Area Agency on Aging involvement in quality assurance programs and in the development of service utilization policies.

- * The Act should require integration between the Area Agency on Aging case management, legal assistance, adult protective services, the long-term care ombudsman, nursing home quality assurance programs, and community based facility programs. At a minimum, working agreements should be required to define referrals and service obligations.
- * The Area Agencies on Aging priority setting process would be strengthened if required to include participation by nursing home and community residential care residents.
- * Area Agency on Aging case management should be integrated with nursing home discharge programs.
- * The Act should allow for a private right of action for the elderly persons who are denied services.

Prepared Statement of Georgia J. Anetzberger

Mr. Chairman. Members of the United States Senate Subcommittee on Aging. Thank you for the opportunity to speak on behalf of the Older Americans Act as a vehicle for protecting the rights of vulnerable elderly.

I'd like to start by acknowledging and supporting the contributions the aging network already makes in this area, focusing my remarks on the problem of elder abuse in Ohio. The Ohio aging network is active in abuse prevention and treatment in several ways: problem identification and investigation, direct services, community education, program development, and service linkage.

More specifically, about 10% of all elder abuse reports come from workers at senior centers, nutrition sites, and offices on aging. In daily contact with older people, they are critically situated to observe changes in behavior and appearance, and report any suspicion of elder abuse that arises.

Although Ohio's Adult Protective Services Act places responsibility for abuse investigation on County Departments of Human Services, occasionally County Departments delegate it to other agencies. In Cuyahoga County, six agencies have designated authority to investigate abuse situations that come to their attention, including some in the aging network, like the Lakewood Department on Aging and Long-Term Care Ombudsman Program. This system works well, because it reduces the number of agency contacts that victims have and increases the likelihood of swift action to address maltreatment.

However, perhaps the greatest contribution of the aging network rests in the vast array of resources it offers to abused elders and their caregivers. Older American Act services, like home delivered meals, legal assistance, and personal care, go a long way in improving the situation of victims and removing the factors that contribute to abuse occurrence.

The other aging network roles in abuse prevention and treatment rest largely with area agencies on aging, state units on aging, and the Administration on Aging. These organizations help educate professionals and the public on elder abuse as a social problem, such as in Ohio through workshops at the Multidisciplinary Institute on Aging and annual Governor's Conference on Aging. They encourage the development of related innovative programming, like the recent Administration on Aging funded guardianship diversion program in Trumbull County. And they promote service

coordination. In northeast Ohio, for instance, the Western Reserve Area Agency on Aging serves as auspice for the Protective Service Consortium for Older Adults, a network of over 80 organizations attempting to deal with elder abuse in our five county region.

Yet, despite the considerable activity and concern of the aging network in elder abuse prevention and treatment, it is not enough. More importantly, it is often misdirected and fails to respect the rights of vulnerable older people.

To illustrate: representing the Protective Services Consortium for Older Adults, I have attempted to offer public education on elder abuse at senior centers and nutrition sites, frequently only to be rebuffed by their coordinators, who were more concerned about arousing fear among participants than assuring that they are aware of a problem that potentially could affect them and their friends.

Other times the aging network has moved toward the use of restrictive legal and service interventions prematurely. For example, a while back the Federation for Community Planning of Cleveland surveyed service providers to identify disorders that were regarded as indicators of the need for guardianship. The findings included arthritis, bone fractures, amputations, and incontinence, none of which would seem to reduce someone's ability to handle finances or decide proper medical treatment. However, for some service providers, they provided a rationale for guardianship.

Similarly, while employed as a consultant in Adult Protective Services to our local County Department of Human Services, I found some in the aging network promoting the safety of older people over their right to self-determination, including the right to elect to live in dangerous circumstances if they are competent to make that decision. The hue and cry from the aging network at such times was "do something, no matter what."

It seems to me that with Older Americans Act reauthorization, we have an opportunity to take stock and refocus, to challenge some of our traditional ways of operating. In this regard, sometimes it seems that in an attempt to fulfill our advocacy function, we in the aging network infantilize the aged, and remove from them the right of autonomy and decision-making. Other times, in fulfilling our service provider function, we curtail the ability of older people to refuse resources, often using subtle methods of conjoining around service receipt. And, finally, sometimes in our attempt to build a service system, we reduce the element of choice in service delivery, limiting the number of agencies funded to provide specific services and reducing the ability of consumers to select services that meet their standards of quality, although perhaps not ours.

I suggest that the aging network needs to raise its own consciousness about individual rights, and reaffirm adherence to American cultural values around freedom, independence, and individualism, and recognize how these values can become circumvented through paternalistic service provision. A bill of rights for vulnerable aged should be included in the directives surrounding the provision all of Older American Act services, and protection of these rights should be monitored by every area agency on aging. I believe that to do otherwise fails to recognize older consumers as adult citizens and continues to define advocacy to mean "resource pusher" instead of "rights promoter."

As examples of such bills of rights, I leave the Subcommittee with two sets developed in Ohio dealing with impaired older persons generally and Adult Protective Services specifically.

Thank you for your attention, and the concern you express for vulnerable older people in conducting a hearing of this nature.

BILL OF RIGHTS FOR IMPAIRED OLDER PERSONS

1. The right at all times to be treated with dignity and respect, regardless of the particular situation.
2. The right to confidentiality.
3. The right to privacy.
4. The right as a competent adult to reject services (including medical treatment) as well as to receive them.
5. The right to attain/retain the highest level of independence, economy and interaction with the community of which he/she is capable.
6. The right to exercise all civil rights unless the person has been adjudicated incompetent pursuant to Chapter 2111 of the Ohio Revised Code and has not been restored to legal capacity.
7. The right to receive professional and competent services.
8. The right to direct and evaluate the services provided to the greatest extent he/she is capable.
9. The right to be free from physical or chemical restraints and prolonged isolation except the minimal extent necessary to protect the person from injury to self, others or property. Restraints should not be used as punishment, incentive or convenience.
10. The right to manage his/her personal financial affairs, or if this management is turned over to another individual, to receive written accounting of financial transactions.
11. The right not to be moved to another place of residence without his/her consent.

Source: Legal Interventions with Impaired Elders: Goals, Roles and Strategies 1984
The Protective Services Consortium for Older Adults of Cuyahoga County: Cleveland, Ohio.

PRINCIPLES OF ADULT PROTECTIVE SERVICES

- I. Freedom Over Safety. The client has a right to choose to live at risk of harm, providing she or he is capable of making that choice, harms no one, and commits no crime.
- II. Self-Determination. The client has a right to personal choices and decisions until such time that she or he delegates, or the court grants, the responsibility to someone else.
- III. Participation in Decision Making. The client has a right to receive information to make informed decisions and to participate in all decision making affecting her or his circumstances to the extent that she or he is able.
- IV. Least Restrictive Alternative. The client has a right to service alternatives that maximize choice and minimize lifestyle disruption.
- V. Primacy of the Adult. The worker has a responsibility to serve the client, not the community people concerned about appearances, the landlord concerned about crime, or the family concerned about finances.



- VI. Confidentiality. The client has a right to privacy and secrecy.
- VII. Benefit of Doubt. If there is evidence that the client is making a reasoned choice, the worker has a responsibility to see that the benefit of doubt is in her or his favor.
- VIII. Do No Harm. The worker has a responsibility to take no action that places the client at greater risk of harm.
- IX. Avoidance of Blame. The worker has a responsibility to understand the origins of any maltreatment and to commit no action that would antagonize the perpetrator and so reduce the chances of terminating the maltreatment.
- X. Maintenance of the Family. The worker has a responsibility to deal with the maltreatment as a family problem, if the perpetrator is a family member, and to try to find the necessary family services to resolve the problem.

Source: G. J. Anezberger. (1988, May). Ethical Issues. Paper presented at the National Conference on Elder Abuse, Milwaukee, WI.

Published in: C. A. Miller. (1990). Nursing Care of Older Adults: Theory and Practice. Glenview, IL: Scott, Foresman.

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Senator ADAMS. And I thank you, and the committee will stand in recess subject to the call of the chair.

[Whereupon, at 12:08 p.m., the subcommittee was adjourned.]